INTERNATIONAL DEVELOPMENT RESEARCH CENTRE

STRATEGIES AND POLICIES FOR HEALTH SOCIETIES

SOCIAL POLICY AND MACROECONOMIC RESEARCH : EXPLORING POTENTIAL LINKS IN RELATION TO HEALTH CARE AND ECONOMICS

FINAL REPORT

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Introduction.

This technical report includes the expected output of the activities undertaken during my Research Fellowship Award in the International Development Research Centre. The activities fulfilled the following objectives:

Review IDRC-funded projects on decentralization and write a proposal on the financial aspects of health care decentralization in Latin American Countries

Review all ASPR and MIMAP documentation and write an essay on the potential links for joint research activity between the two Pis.

Work with Dr. Enis Baris, on a theoretical paper on macroeconomic adjustment policies and their impact on health care.

Assist ASPR and MIMAP Program Officers in Ottawa, on issues related to health economics.

The outputs enclosed in this report include the following documents:

Research proposal: The financial analysis for health care decentralization. A comparative study for developing countries.

Essay: Common grounds and potential for cooperation between ASPR and MIMAP PIs.

Working paper: Financial indicators for health care decentralization in developing countries. A framework for analysis.

Comments, sugestions and proposal for reestructuring the manuscrit: Macroeconomic Adjustment Policies, Health Sector Reform and the Impact on Acces, Utilization and Quality of Health Care.

Comments and sugestions for research proposal reviewed.

It is important to stress that each of the documents contained in this report includes the detailed report and results of each activity developed during a three months periods at IDRC.

Appendix 1.

The financial analysis for health care decentralization: A comparative study for developing countries

INTERNATIONAL DEVELOPMENT RESEARCH CENTRE

RESEARCH PROPOSAL

THE FINANCIAL ANALYSIS FOR HEALTH CARE DECENTRALIZATION: A COMPARATIVE STUDY IN LATIN AMERICAN COUNTRIES.

Principal Investigator: Armando Arredondo.

August, 1997

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CHAPTER 1: STATEMENT OF THE PROBLEM.

1.1) Problem statement and the objectives of the study.

The objectives of decentralization, in an international perspective, have been diverse. On a philosophical and ideological level, decentralization has been seen as an important political ideal, providing the means for community participation and local self-reliance, and ensuring the accountability of government officials to the population. On a pragmatic level, decentralization has been seen as a way of overcoming institutional, physical, financial and administrative constraints on development. For instance, increased local control can result in a better response to local needs, improved management of supplies and logistics and greater motivation among local officers, thus facilitating and speeding up the implementation of development projects. It has also been seen as a way of transferring some responsibility for development from the centre to the periphery and, as consequence, a way of spreading the blame for failure to meet rural needs (Cassels, 1995).

Decentralization is one of the principal elements of health sector reform in a wide range of countries. It is increasingly recognised, in both national and international levels, that management, financing, planning and policy functions in the health sector may be carried out more efficiently and effectively, if they are decentralized transferring responsability at local level. There is also a growing concern that decentralization has failed to achieve the objectives for which it was introduced and can indeed have effects that limit health sector development (Cheema-Rondinelli, 1983. Collins, 1994).

The relationship between decentralization and financial changes in the process of health care reform for latinamerican countries is complex. Decentralization is a term which is used to refer to a wide range of organisational structures and processes, each of which may affect the financing of health systems differently. Health financing is an equally complex concept, which has many different aspects and components, each of which can be influenced by decentralization in different ways. The relationship between a specific form of decentralization and financial aspects may be direct or indirect, and can be complicated by the fact that decentralization is only one of many sets of factors affecting the process of health planing and financing in the context of health transition of both, the health conditions and health systems.

It is also important to note that several national political systems in Latin America are undergoing a process of transition from nondemocratic to more democratic forms of governance. Countries such as Ecuador, Brasil, Argentina, Chile and Peru are in a stage of transition of political system. As reforms are undertaken, it is not unreasonable to expect that local bases of power will be develop and give rise to increasing pressure for decentralization. If this trend toward greater political democratization continues and is supported by complementary social and economic developments, the prospects for greater political and administrative decentralization in Latin American countries may prove to be much more favorable in the near future than they have been in the past and are at present (Harris, 1981).

The study of health care financing and decentralization is a complex and multifaceted issue in Latin

America. Analysis of recent attempts at decentralization and financial changes requires an understanding of the contradictory forces at work within the political systems, and particularly the bureaucracies of Latin American countries, in which strong centralizing tendencies coexist with particular forms of bureaucratic decentralization. Centralizing tendencies remain predominant, and decentralizing forces both are caused by and serve to reinforce them.

The form and degree of decentralization is strongly influenced by the dynamics of financial aspects, including sources of finance, agents, providers, final destiny and mechanisms allocation of the local, regional and national level, were finance is granted by the state, by the method of allocation. Local governments usually have authority to levy taxes. However, in a developing country setting, the great majority of national revenues often come from indirect taxes, especially customs and excise revenues, and buoyant local sources of revenue are hard to find. The local governments are often by necessity heavily dependent on grants from central government. In addition, governments often retain central control over finance in order to promote geographical equity. In respect of sources of finance, local government may therefore not differ significantly from the local offices of central ministries, though the way the grant is made is likely to differ (Mills et al, 1990).

Many Latin American countries have tried to decentralize their health care systems in different ways, with different results, including strengths and weaknesses for each country. The results are highly related to the changes in the mechanisms for financial resources allocation, and specially with the new financing dynamics for health services in the context of health care reform. The financing study of health care decentralization quantifies the amounts of resources involved and it analyses the sector dynamics, its opportunities and sufficiency. At the same time, it intends to mobilize and reassign resources within the system at national and regional level. The objective of the policy is to assure that the impact of the health expenditure is optimal. These goals suggest the need to adequate resource collection and resource allocation for decentralization and requires as a basic input several micro and macroeconomics indicators that identify and monitor the financial problems and the need of change, as well as the opportunities so that this change achieves the maximum level of equity, quality and efficiency.

Taking into account the aspects mentioned in this section, **the general objective** of this research proposal is to analyse and to identify, ~~under~~ economical ~~perspective~~, the effect of health care decentralization on the financial policies to improve equity and efficiency for the production of health services at local levels in latinamerican countries. **The specific objectives** are:

- Assess the effects of health care decentralization on the financial aspects, in order to determine their impact on policy formulation, integration, and program delivery, and to identify strengths and weaknesses in each country.

- Develop economic indicators, methodological and conceptual instruments ~~on~~ health economics to the analysis of financial aspects for health care decentralization.

- Promote the exchange of research results on health care financing and decentralization.

1.2) Historical background and justification.

Writers on decentralization trends and financial changes in developing countries point to two major phases of interest in decentralization (Mills, 1990. Collins, 1993). In the 1950s and early 1960s, decentralization -in the form of a system of local government- was promoted by colonial administrations as a necessary element in the structure of an independent democratic state, as a means of political education for the population, and as a way of establishing local responsibility for providing some local services. The structure proposed and set up were usually based on British or French models of local government, though limited in their powers and functions.

Many countries are attempting to strengthen local level administration within existing government structures, with corresponding interest in the most suitable administrative mechanisms. In Latin American countries such as Chile, Peru, Mexico, Argentina, Brasil, Nicaragua, and Costa Rica, decentralization of power from central and intermediate levels to local units of government has not until very recently been a major feature of contemporary administrative reforms, and the existence of an "administrative vacuum" at local level has been suggested (Mills, 1994).

There is a strong tendency toward centralized bureaucratic control and paternalistic dependence on the national government to finance, plan, and manage development efforts present a kind of obstacles to implement the process in Latin America (Taussig, 1978). Because of the dominant centralizing tendency and premature bureaucratization of the Latin American political systems, the prospects in general are not very favorable for the successful implementation of political and administrative decentralization forms that are based on the devolution of power from the national to the local level. This does not necessarily mean that devolution of authority to local government will not be attempted or that, if attempted, it will not succeed (Chema-Rondinelli, 1983, 1989).

Concentration of decision about health policies and resource allocation within central levels, often referred to as overcentralization, is a fundamental characteristic of Latin American countries. Thus it is not an accident that the deconcentration of decision making has become an objective of contemporary administrative reforms. The term "decentralization" frequently refers to efforts at deconcentrating or delegating decision making from the headquarters of central level to their lower echelons or field offices (Hurley, 1995). Devolution of power from central level to local units of health has not been a major feature of contemporary health care reforms in Latin America.

The development of local health units has been severely retarded by the lack of financial resources and by the steady encroachment of central government agencies that carry out programs and provide services at the local level. In fact, local governments have been barely able to survive. In a very real sense , the proliferation of central government bureaucracies has taken place at the expense of local government in Latin America. The central governments have absorbed an increasingly greater portion of the financial resources available to the health sector, leaving very little to the already poor local governments.

The financial changes for decentralization has been done according to the current health financing

features!

aspects. For latinamerican countries, public treasury funds are the principal sources of financing for central and local government health spending. In addition, compulsory contributions of employers and employees to social security systems or health and welfare funds are the major sources of financing for the expenditure of social security health care programs (Govindaraj and col, 1997) .

Public treasury funds from tax revenues are the principal source of financing for the ministries of health in the countries of the region. This source of financing accounted, on overage, for 90% of the total resources of ministries of health in the countries. The second important source of financing for health institutions are grants and loans, which provide around 6% of the total. In some countries (Bolivia, Honduras and Nicaragua), the latter source of financing has covered as much as 30% of the total expenditure of these institutions. Charges for services provided only a small proportion of the total financing of government institutions- around 4%. There were some important variations in the composition of financing among the countries. These variations are explained largely by the relative magnitude of the resources mobilized through loans and grants. In the case of the smaller countries, annual changes in the composition of financing are strongly influenced by variations in the flow of resources from loans and grants (PAHO, 1995).

In order to stress the financing function for decentralization schemes in latinamerican countries according to the source of financing mentioned above, we can give two countries experience to close this section: In Brazil, for example, over the last several decades the proportion of total fiscal resources going to municipal government has steadily declined as federal government revenues have increased. Tax receipts of municipal governments in Brazil have declined. Meanwhile the proportion of total tax receipts going to the federal government has risen (Harris, 1989). It is important to note that financial resources of Brazilian municipal governments have been reduced as a result of the tax reforms, which have favoured the federal government over state and municipal governments. As a consequence, the administrative capacity of municipalities has been seriously limited by their shortage of funds. Although the new constitution has set up mechanism to increase the counties' revenues, this is not enough to cope with all the new responsabilities established, particularly in the health sector where the workload has been deconcentrated but the funds are still centralized (Araujo, 1997).

The financial imbalance in Mexico is even worse. The total amount of the budgets of all state and municipal governments is less than 10 percent of the federal government's budget. Recent financial reforms in Mexico have merely deepened the problem. The federal government has attempted to strengthen the role of municipal governments by reducing its involvement in local affairs, but this effort has not improved the status of municipal governments because they have inadequate financial resources, trained personnel, and political support. Federal level continues to carry out the bulk of projects that provide local health services and functions (Gonzalez-Block, 1992).

Finally, while the funds are still centralized, a vicious circle of administration under development and fiscal poverty exists among local governments in Latin America. Because of their lack of financial resources, local governments have difficulty covering their basic expenses for health care decentralization.

CHAPTER 2: LITERTURE REVIEW.

In this chapter, there are four levels of approach to analyzing the relationships between financial aspects and decentralization. With the purpose of building on what has been done in the past, it includes a review of : the concept and the meaning of health care decentralization, the concept and the meaning of financial aspects in health care, methodological and conceptual issues on decentralization and financial analysis, and financial issues for health care decentralization.

2.1) The concept and the meaning of health care decentralization.

2.1.1- **The concept of decentralization**. Decentralization for health care is defined here as the transfer or delegation of legal, political, technical and financial authority to plan, make decisions and manage public functions for health systems from the central government and its agencies to field organizations of those agencies, subordinate units of government, semi-autonomous public corporations, area-wide or regional level development authorities; functional authorities, autonomous local governments or non-governmental organizations (Rondinelli, 1981).

2.1.2- **The meaning of decentralization**: Health and health-related services, while they can be looked at as a system in their own right, are also part of a wider government and social system that places limitations on their behaviour. It is therefore important to describe and analyze the main forms of decentralization and to see what they imply for the organization of health system in Latin American countries.

Decentralization can be broad or constrained in scope. The degree of responsibility for and discretion in decision making that is transferred by the central government can vary, from simply adjusting workloads within central government organizations, to the divesting of all government responsibilities for performing a set of what were previously considered to be public sector functions. This evident complexity makes it necessary to distinguish among the major types of decentralization that have been tried in developing countries (Bossert, 1996). According to Rondinelli's approach (1981), they can be categorized into the next four types:

-Deconcentration. The term "deconcentration" is applied to the handing over of some administrative authority to locally-based offices of central government ministries. In the case of health, an example would be a district-level office of a ministry of health. Since deconcentration involves the transfer of administrative rather than political authority, it is seen as the least extensive form of decentralization.

-Devolution. This type of decentralization is the creation or strengthening of sub-national levels of government (often termed local government or local authorities) that are substantially independent of the national level with respect to a defined set of functions. They normally have a clear legal status, recognized geographical boundaries, a number of functions to perform, and statutory authority to raise revenue and make expenditures. They are rarely completely autonomous, but are bodies largely independent of the national government in their areas of responsibility rather than subordinate

administrative units as in the case of deconcentration.

-Delegation. It involves the transfer of managerial responsibility for defined functions to organizations (often termed "parastatal organizations") that are outside the central government structure and only indirectly controlled by central government. Governments may see delegation as a way of avoiding the inefficiency of direct government management, of increasing cost control, and of setting up an organization that is responsive and flexible. In the health field, delegation has been used to manage teaching hospitals and to organize the provision of medical care financed by social insurance, specially in some Latin American countries.

-Privatization. It creates a contractual relationship between public entities and private providers of services. Privatization involves the transfer of government functions to voluntary organizations or to private profit-making or non-profit-making enterprises with a variable degree of government regulation. Many developing country governments have long depended on voluntary organizations for the provision of health services. Some have seen this as a temporary phenomenon, the services to be absorbed by the government once resources permit.

Some governments have used all four types, simultaneously or at different times. Some began with one approach and later shifted to another after assessing initial results. Other governments have used various combinations of the four. A number of countries have devolved development management responsibilities to local governments but have maintained strong indirect controls over them (Abel-Smith, 1988) . Privatization has usually evolved from situations in which private sector firms began offering goods and services that government provided poorly, or not at all, or only in some parts of the country, rather than from deliberate efforts by governments to divest themselves of public functions (Berman, 1996).

Decentralization of government authority can thus take a variety of forms. Moreover, countries may make use different types at the same time for different functions. For example, certain government functions may be devolved to local government, while others are deconcentrated to local administrations of government ministries (Dahlgren, 1990) . The distinction between the four types of decentralization is based essentially on their legal status. In reality, however, other factors (e.g., financial authority, means of representation of the local community) are also important in a particular country may have features from more than one type. Thus, the four type of decentralization presented should not be seen as necessarily clearly distinct from each other. The characteristics of deconcentration and devolution, for instance, may overlap, and a reform in a particular country may have features of both. In particular, forms of local government with a high degree of autonomy tend to be rare in Latin American countries; instead, health local institutions have been created that provide some local discretion while retaining substantial central influence from the ministry of health, particularly over policies and resources (Cassels, 1995) .

2.2) The concept and the meaning of financial analysis for health care decentralization.

2.2.1.- The concept of financial aspects The financial aspects for decentralization includes the analysis of several financial indicators to understand the changes in the financing policies for health care reform in Latin American countries (Arredondo et al, 1993). The most commonly used conceptual framework of dynamics financial aspects for health includes the definition of health expenditure on activities whose primary purpose is health improvement. This excludes large programs which have health effects, but whose primary goal is not health: for example, general foods subsidies, housing improvement, and large urban water supply projects. However, this definition does leave room for significant differences in how countries account for health-related programs such as targeted nutritional services and water quality improvements (Hernandez et al 1995. Ramesh, 1997).

Recently there is a new and more appropriate method to analyse the financial dynamic in health care with recent applications for developing countries was identified and is called National Health Accounts. The core concept of national health accounts is defining the **flow of funds**. Experience in applying this concept in developing countries suggests that approaches used in countries like the US should be adapted to the specific needs of developing countries, as well as the more limited data available, and according to the research questions. This requires modifying definitions of both sources and uses (Berman, 1996).

One approach, used in Egypt, Mexico, and Colombia, is to formulate the flow of funds in terms of three major levels: the original ***sources of finance***, the ***financing funds,*** and the health care ***providers*** (Frenk et al, 1996). Taking into account the objectives and the research questions for this study, in order to analyze the financial aspects for health care decentralization, we aggregate two more levels: the **final destiny** or financial resources utilization for different health programs and the **mechanisms for financial resources allocation**.

2.2.2.- The meaning of financial aspects for health care decentralization. Independently from the patterns of decentralization, as was mentioned at the beginning of this section, there are five indicators that must be defined to analyze and understand the financial aspects for health care decentralization: **The financing sources, the financing funds, the health service provider institutions, the final destiny of the resources**, and the **mechanisms for financing allocation.**

-The financing sources. Could be defined as the primary economic sources that provide the resources to the population for different activities. Depending on the origin of the economic amounts, there are four sources of financing, classified as internal and external. In the case of the health system, the internal sources consist of the government, the industry and the households. The external ones are referred to the exchange that takes place within the health sector, through multilateral or bilateral agencies (Mills, 1991).

-The financing funds. The financing funds are the reservoirs of the economic sources, their role is to administrate the resources and to buy the medical services, these could be real or virtual funds. This is important since the virtual funds can only be used in an individual manner and they are in constant competition with the acquisition of other satisfies. They depend on the individual preferences and they could be drastically reduced at times when the income drops, as a result of economic crisis

and the adjustment policies.

-**The health service provider institutions.** The health service provider institutions are the government and non-government organizations providing health care services for the population. According to the source of finance and the consumers, the provider institutions are classified in three: social security, public assistance and the private sector (Lee, 1983. Frenk, 1996).

-**The final destiny of the resources.** It refers to the classification of the health expenditure by the health service providers, according to their final destiny and depending upon the financing fund. For this reason, the following criteria will be used for the classification: for supporting programs, for current expense factors and investment and for the care units.

-**Mechanisms for financing allocation**. The mechanisms for financial resources for health expenditure include legal, political and technical principles that permit a way for financial resources allocation for the production of health care services, and for the financing adjustments for health care decentralization.

2.3) Methodological and conceptual issues on decentralization and financial analysis.

Although there has been a growing literature on general decentralization of public administrations, usually examining in general terms financial flows, there has been remarkably little concrete and research on the forms and impact of decentralization in the health sector and on the details to respect the effectiveness and efficiency in the financial changes and the new resources allocation mechanisms. The dominant publications are largely conceptual and descriptive of single cases, with some recommendations based on expert opinion. There has been little systematic comparative empirical research.

What does come from this research, however, are disturbing case studies of the problems of decentralization (Campos, 1995). Many of the cases , largely project evaluations funded by donors, show that poorly designed and implemented programmes of decentralization do not reach expected objectives, and may indeed make matters worse. Of particular concern is the evidence of local decisions in favour of curative higher cost services, putting preventive programmes at risk (Holley, 1995).

Also, most of the research to date has focussed on the public administration approach and very little has evaluated the regulated market approach. One of the best synthesis of research utilizing the public administration approach is by Mills and collaborators, whose overview of decentralization issues shows far case studies and expert opinion can go (Mills et al, 1990). It is an excellent summary of the state of art and holds good advice. It, however, does not provide sufficient empirical evidence to back up most of its analysis. This is not a fault of the overview, it only demonstrates that not enough good research has been done.

A central problem is that few research projects have developed systematic definitions, conceptual frameworks and consistent methodologies to produce consistent, valid and reliable results for comparative studies among countries. A major research problem is the difficulty of developing countries' criteria for evaluating decentralization that can go beyond the general preferences of the "eye of the beholder". Community level officials and advocates tend to prefer greater authority and responsibility -if it comes with access to resources- and central level officials and advocates tend to resist giving up control of operations and resources.

Associated with this problem is a key methodological problem of isolating decentralization effects from other system changes which might influence outcome and output variables. When decentralization occurs, there are usually short term transaction costs, lags in implementation and changes in other independent variables that complicate measurement and attribution of dependent variable change (Bossert, 1996).

Although the existing research may have informed government officials and international technical assistance, it is not clear that the advice is consistent enough to be persuasive. Most decentralization programmes in the last twenty years which have followed the public administration approach have had little impact on transfer of power away from the central national offices. It is decentralization that was been motivated by an ideological commitment to market oriented public policy that may have had more success in transferring power. Currently, major donors to international development, whose policies have been informed by particular ideological orientations, are strongly encouraging developing countries to adopt decentralization (Bossert, 1996). These decentralization policies have, however, not been informed by proof of effectiveness and efficiency in the changes for financial aspects, particularly with the resources allocation in the context of health care reform initiatives in developing countries.

2.4) Financal issues for health care decentralization.

According to the analysis of health financing in latinamerican countries (PAHO, 1995), the method of allocation of national government revenue can vary from grants that are not earmarked for any purpose (often termed "block grants") to those that are closely tied to particular activities and expenditures. At one end of the spectrum, a fixed percentage of national revenues may be earmarked for local government and divided between local governments according to some measure of their "need", possibly including some requirement for the local authority itself to raise a certain minimum sum. For instance, in some developing countries a fixed percentage of the statutory allocation from federal level to other levels of government is earmarked for local government, as is a minimum proportion of state revenue. One quarter of this funds is divided equally between local authorities; the remaining 75% is distributed according to population (Gilson, 1995).

A less permissive method is to tie grant to particular local functions. For example, in some countries the expansion in rural health services is funded from the national level . The proportion of the total available for health is first decided between the National Planning Offices and the Ministries of Health, and the funds are then divided between provinces on the basis of various indicators of "need". Finally,

each province and the health authorities discuss how the provincial allocation will be spent (Gilson 1995).

A similar method can be used for the allocation of recurrent and capital funds to deconcentrated local administrations of ministries of health. In many countries it is customary for allocations to be made on the basis of past allocations, thus permitting inequalities between districts to persist or even worsen. This approach can be replaced by resource allocation formulate that reflect the "need" of each district (McPake, 1991). At the least, size of population should be entered into the formula. Further refinements could be to weigh the population by indicators of health service need, for instance mortality and morbidity rates, or of socioeconomic status, for instance, average local per capita income.

The inadequacy of financial resources and the inability to allocate and expand them effectively were noted in evaluations of health care decentralization in nearly every developing country. The lack of independent sources of revenue weakened the local organizations ability to carry out its tasks. The dependence on central government grants kept the local organizations under the control of the central bureaucracy. Even in countries which devolved revenue raising powers to local governments, localities remain dependent on central funding for most of their activities. After more than a decade of devolution in some countries the provincial councils still receive about 55-65 percent of their revenues from central governments grants (Harley, 1995).

A detailed study of decentralization in developing countries stressed financial problems of the provinces and their impacts on decentralized administration. The survey revealed that the amounts of financial resources transferred to the province through the budget were far below the minimum amounts needed to implement functions transferred from the central ministries. The Ministry of Finance cut the budgets requested by the province's executive councils by 50 percent in some years. The provinces were never reimbursed for minor public works expenditures made during previous fiscal years. At the same time, the central government increased the amounts that the provinces would have to collect in local taxes to levels far beyond their capacity. The result was a severe shortfall in revenues that constrained the executive council's ability to provide services or undertake development projects (Gilson, Mills, 1995). The revenue base is simply too small to provide adequate tax resources. The forms of taxation that can be imposed on subsistence economies are extremely limited.

Shortages of skilled personal and financial resources have also undermined decentralization in Latin America. Because they lack financial resources, the local governments have difficulty covering their basic operating expenses, training their personnel, making organizational improvements, obtaining technical assistance, and expanding the range and quality for health services. Harris notes (1983): "Their limited funds make it impossible for them to improve their administrative capacity. Their limited administrative capacity discourages the allocation of new functions for fear that they will not be able to carry them out effectively or use the funds given to them efficiently. Finally, their limited administrative capacity greatly hinders their ability to levy and collect taxes or mobilize their own sources of revenue".

In Mexico, budgetary resources have been reallocated in several ways. Although total federal government expenditure on health has been reduced, the proportion assigned to the health sector increased from 7.5% in 1982 to 8.6 in 1986. Financial resources on services for the uninsured population rose from 27% in 1983 to 33% in 1985. The financial resources to produce health services by the states has grown by an annual 20% in real terms during the period 1984-1986, while the central administrative units have seen theirs reduced by 19%. The states increased their own contribution for health financing by 280% between 1984 and 1985 and the social security institutes also increased the participation in the financing of public health activities. (Alvarez, 1990)

Analysing financial delegation in the decentralization of health services in Mexico, two constant factors set a common pattern between decentralized and centralized health service organization: the continuation of separate federal and state sources of finance -without the state meddling with the federal funds; and the maintenance of the federal labour relationship with all state health workers- right up to the director or minister of health. Thus, all decentralized state health services, whether called ministries, departments or institutes became -from the point of view of finance and control- de facto, parastatal organisms of both the state and the federal governments (Frenk-Gonzalez, 1992).

In Brasil, the new mechanism of funding health system, whereby payments are made by a national institution for medical assistance for the services performed by state and county health secretariats, has established a financial dependence that is incompatible with the devolution and autonomy of the different spheres of power. For instance, counties cannot spend this money on one particular local health policy- a health education program, for example-but can only spend the money on hospital treatment and outpatient consultations (Araujo, 1997).

In Colombia, there is numerous laws and regulations on power-sharing with municipalities which are only now coming to fruition in the context of municipal life. In Colombia's daring vision of decentralization, 41% of incoming revenues will be transferred to the departmental and municipal levels by 2000. But decentralization is bearing fruit in Colombia. Municipal tax revenue rose from 4.7% to 7.6% between 1980 and 1991 (while income from national taxes stayed at 83% and the provincial level dropped). Spending has kept pace with revenue. Municipalities' contribution to the gross domestic Product is increasing (Andrew, 1997).

In Chile, capital investment funds are now requested through the regional financing system, which is under the direct control of the regional governor. Most new proposals for local projects or programmes are now decided upon by the area health services themselves. Decentralization has resulted in quicker management decisions, for example on staffing matters; however, decentralization has had two important adverse effects. It has made national control of the distribution and transfer of health workers much more difficult. In addition, since financial resources are more limited, it has become harder to finance large capital projects and new programmes, without new financial allocations being made by the Ministry of Health. (Montoya, 1990).

In sum, both centralizing financial authority and decentralizing administrative authority tendencies coexist in the health systems of Latin American countries. In a complicated and often seemingly

confused manner, these tendencies combine and conflict with one another, with the centralizing tendency remaining unquestionably dominant. However, this tendency results in the overconcentration of decision making at the top of the hierarchical structure and in turn generates decentralizing efforts aimed at decongesting the overloaded apexes of decision making within central ministries of health. In this environment, the posibilities for the devolution of financial power from central bureaucratic agencies to local health units are not very favorable. In this sense any financial issue for health care decentralization is related to the new financial authority and control at local level on source of finance, funds of financing and new mechanisms for resource allocation and final use of financial resources at local level.

1 - Mostly Mexico, Brazil, Colombia

2. I am not sure one can talk about an explicit and formal decentralization policy in Mexico

3. The lit review in substantive areas of financing and decentralization e.g. country experiences needs to be beefed-up

4 - The five elements need to be further developed.

CHAPTER 3: THEORETICAL MODEL AND RESEARCH HYPOTHESES.

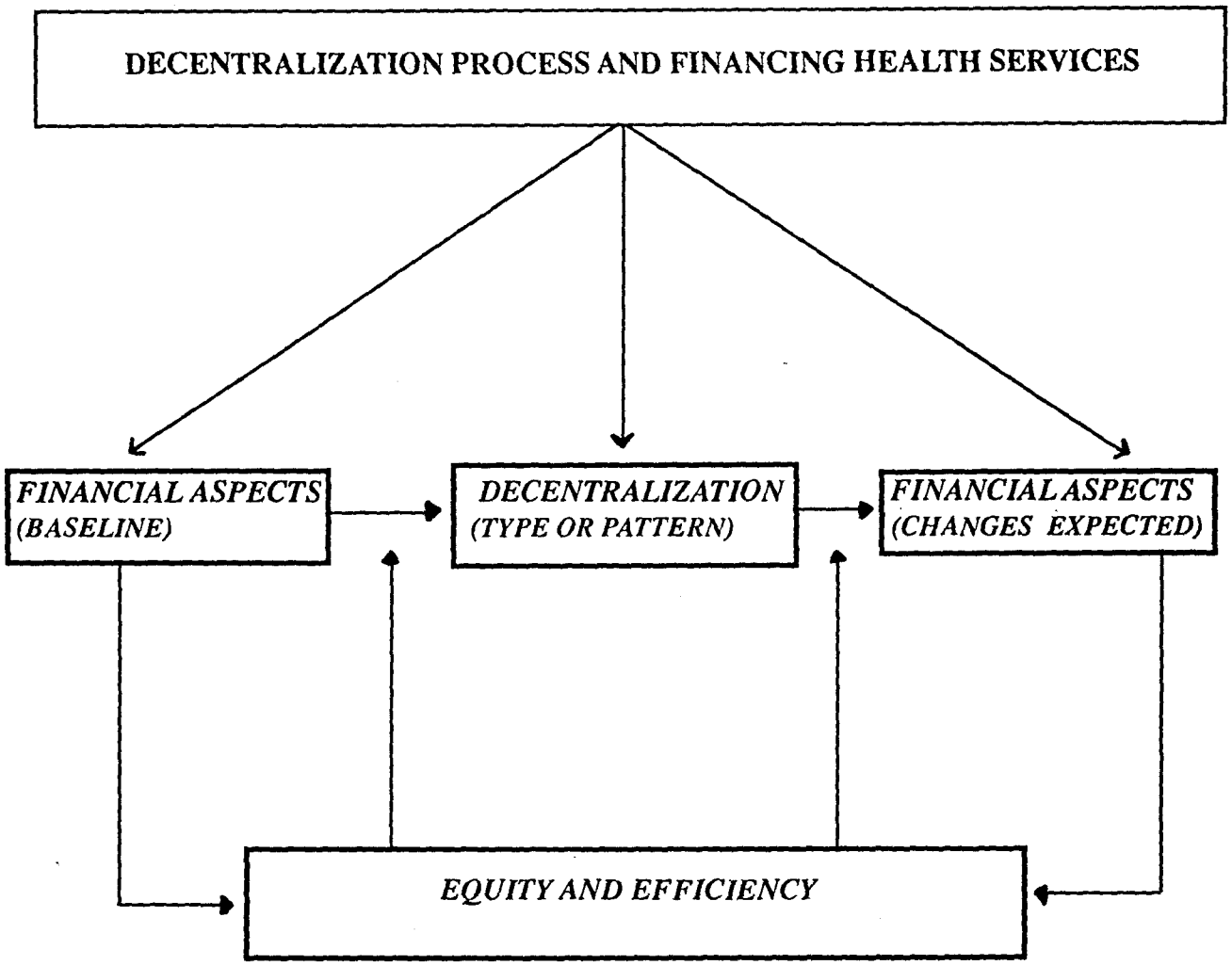
In this proposal, the theoretical model includes three main variables of analysis: financial aspects before decentralization, decentralization process, and financial aspects after decentralization. The model also includes five levels of effects according to the indicators to analize the financial aspects in the context of health care decentralization: The effects of decentralization on the source of finance, the effects of decentralization on the funds of financing, the effects of decentralization on the providers, the effects of decentralization on the mechanisms for resource allocation, and the effects of decentralization on the final use of resources. In this sense, and in order to identify the elements to build the research hypotheses, figures 1 and 2 intent to show the effects and relationships between financial aspects and decentralization in the context of health care reform for Latin American countries.

Figure 1, includes three main variables that may identify, in general terms, the elements of analysis on financial adjustments for the equity and efficiency of the decentralization process in the context of health care reform. The antecedent variable is represented by financial aspects before decentralization , the predictor variable is represented for the type or pattern of decentralization implemented, and the dependent variable is represented for financial changes after decentralization. There is a modifying variable represented for the equity and efficiency before and after decentralization affecting before the type of pattern of decentralization designed and implemented and after the adjustments on financial aspects.

Figure 2 illustrates in a more detailed way all elements of analysis and the hypothesis derived from the theoretical model presented in figure 1. The scheme identifies the basic indicators of the flow and allocation for financial resources before decentralization: source of finance, funds of financing, providers, mechanisms for resource allocation and final use of resources. The scheme also identifies the main effects of decentralization on the financial aspects, according to the changes expected after decentralization: more control financing and authority at local level, more revenues at local level, decrease or increase in local funds according to local preferences, budget control for providers according to priority groups at local level, new technical, political, social and legal principles to design and implement new mechanisms for resources allocation and setting priorities for final use of resources in relation to helath system and health conditions population variables.

The process and the impact of the expected financial changes depends on the type of pattern of decentralization that is implemented in order to get more equity and efficiency in the use and allocation for financial resources during decentralization. In this figure it is important to stress that financial indicators, changes expected in health financing, and results on efficiency and equity, have an indirect relationship with the type or pattern of decentralization that each country implements. In this way there is a circular relationship that provides feedback and assesses constantly the objects of study in this research proposal: financial indicators, decentralization procces, and efficiency and equity principles. According to the theoretical model exposed, following is a brief statement of the main hypotheses that this research proposal intends to test.

FIGURE 1: THEORETICAL MODEL (I). RELATIONSHIPS BETWEEN FINANCIAL ASPECTS AND HEALTH CARE DECENTRALIZATION.



Source of finance.

Many changes in responsibility for sources of finance occur as a result of decentralization, independently the type and the pattern. The local government is required to assume some responsibility for health care financing. Therefore local level must assume more control financing and authority on the absolute amounts of financial resources. It also include more and new strategies to raise revenues locally and to negociate with national and international levels the control on source of finance (Abel-Smith, 1967. Mills, 1990).

Funds of financing.

The effect of the financial changes in the reservoir in the initial stages of decentralization is that economic sources could be reduced. In the decentralization process they depend more on individual preferences and they could be drastically reduced at times when the income drops at local level, and as result of economic adjustments for the new budget to every fund of financing (WHO, 1993. WB, 1993. Hsiao, 1994).

Providers.

The changes affect the nature and range of resource allocation and budget control at different levels by each institution (public assistance, social security and private sector). In order to have more budget control each provider institution must design a new monitoring and assessment programme for final use of resources and new mechanisms for resources allocation (Abel-Smith, 1988. Frenk, 1996).

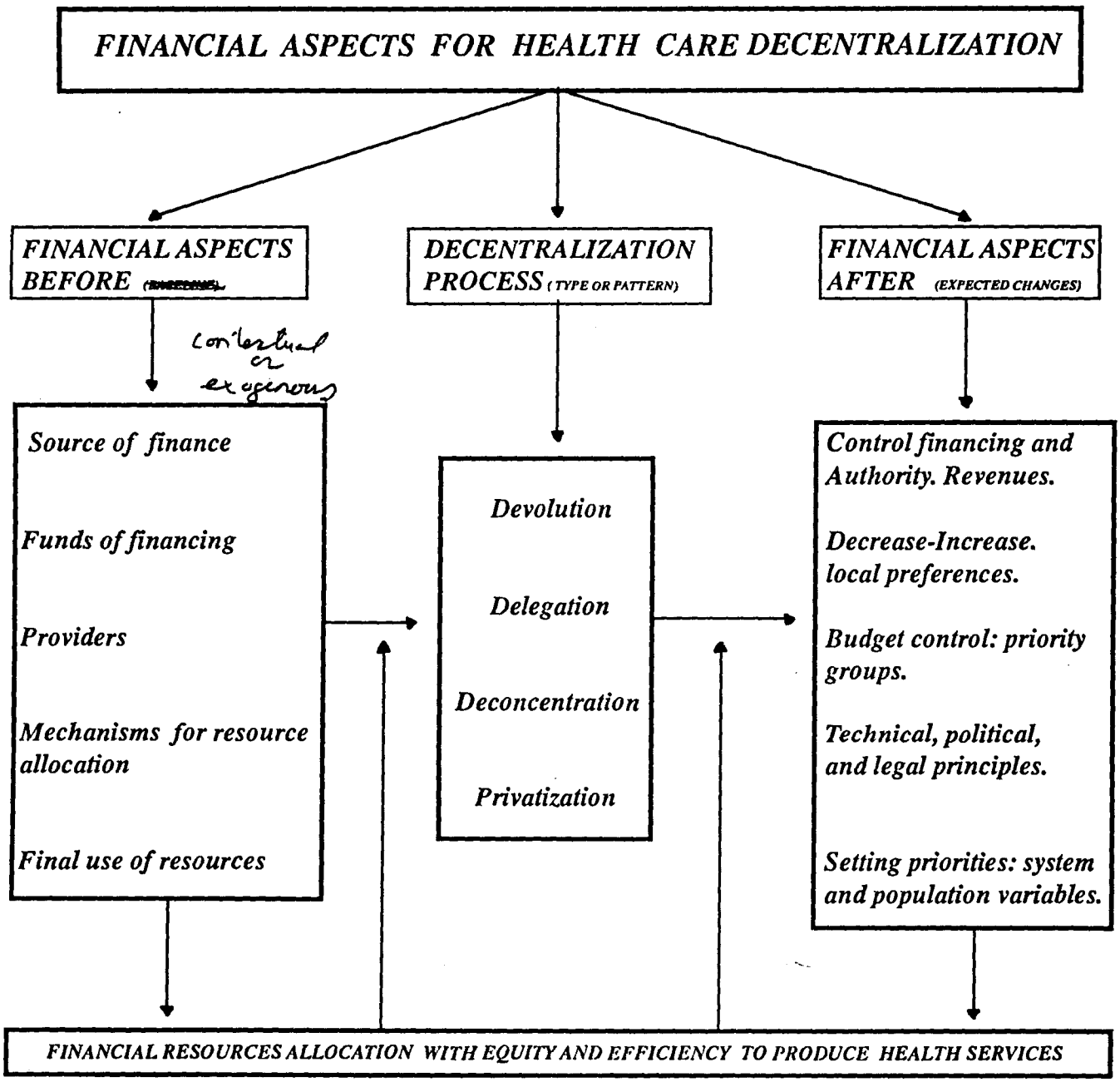
Resources allocation.

The effect of decentralization process on resources allocation is very much related to epidemiological changes at local level and to the new technical, political, legal and institutional principles to implement new mechanisms for resources allocation and to analyze the financial resources required for following years at local level. It must include mechanisms designed with the combination of three variables: type of medical care (prevention, promotion, curative, rehabilitation), type of disease (infectious disease, chronic disease, accidents and violence), and type of institution (public assistance, social security, private sector) (Bobadilla, 1990. Arredondo, 1997).

Final use of resources.

With the decentralization process health policy makers at local level must design and improve new and different equity ways for the final use of the resources depending on local health priorities and according to two major variables: system variables (the supporting programs, the current expense factors and investment, and the health services to produce), and population variables (include the type of services demanded at local level: primary care, secondary care and third care) (Musgrove, 1990. Jamison, 1991).

FIGURE 2: THEORETICAL MODEL (II). RELATIONSHIPS BETWEEN FINANCIAL ASPECTS AND HEALTH CARE DECENTRALIZATION.



CHAPTER 4: RESEARCH METHODOLOGY

The study will have two phases: a feasibility study and a full study. The feasibility study will validate the research strategy, the data collection instruments, and data analysis with institutional documents in three countries. The analysis plan will also be tested, and a final research strategy outlined.

The full study will include a comparative analysis of 6 Latin American countries. This proposal refers to the general research strategy for both the feasibility study and the full study.

4.1.) Study design

4.1.1.- Type of study design

Due to the nature of the project, the research will follow a multipurpose longitudinal design (Figure 3). The main thrust of the design is the combination of a comparative approach, under a hybrid before-after design, using data at different levels of observation, and of both qualitative and quantitative nature. The design will also use a retrospective time orientation.

4.1.2.- Comparative approach.

The study will follow a comparative approach. In both the feasibility study and the full study group of countries will be selected. The variables included in the conceptual framework will be defined, operationalized and measured the same way in each country. Thus, we will be able to make inter-country comparisons based on all the variables and how they vary over time, and across and within countries.

4.1.3.- Before-after assessment.

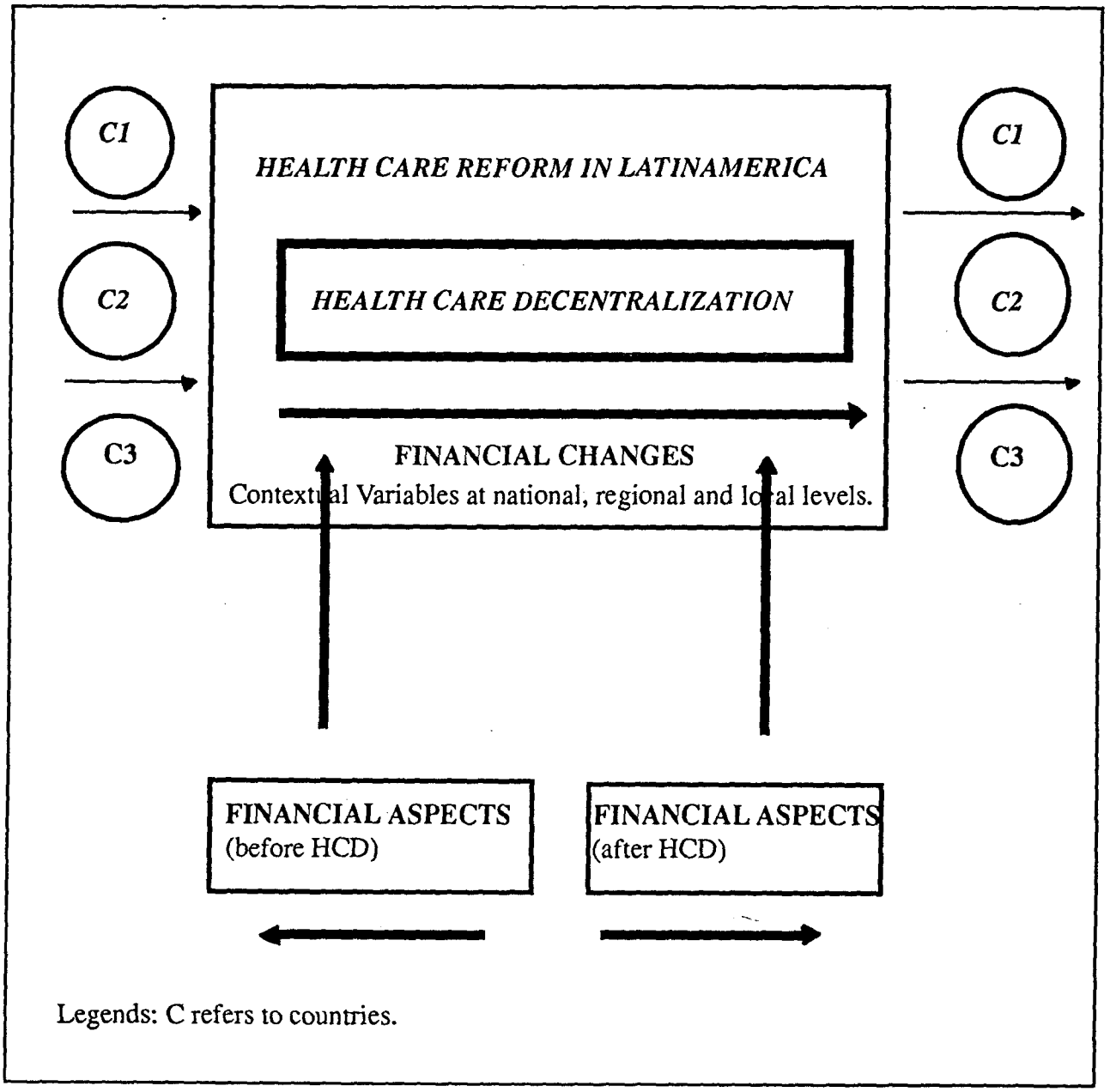
The main criterion for country selection will be that they have undergone financial changes and health care decentralization. The first measurement will be carried out based on data available in a year when financial changes and health care decentralization were introduced in the national health systems. This will serve as the baseline measurement for the study. The second measurement will be carried out one year after the financial changes were implemented. This will correspond to the measurement after the decentralization.

4.1.4.- Levels of observation.

The study considers multiple levels of observation: institutional, local, regional, national, and international levels. Each level will correspond to the nature of data available for each one of the groups of variables and indicators presented in the theoretical model before and after decentralization:

-Source of finance
-Funds of financing

FIGURE 3: FINANCIAL ASPECTS FOR HEALTH CARE DECENTRALIZATION IN LATINAMERICAN COUNTRIES. STUDY DESIGN



Legends: C refers to countries.

-Provider institutions
-Final use
-Mechanisms for resource allocation

4.1.5.- Nature of the data.

Given the objectives and the scope of the project, it will be necessary to gather data of both qualitative and quantitative nature. This we deem necessary as the only way possible to assess the major effects of health care decentralization on health financing. This type of design will need a multi disciplinary research team, and possibly the participation of multiple research groups within each country.

4.1.6.- Choosing countries.

Below gives a list of criteria to be used for the selection of the countries in the study in order to be able to fulfill the research goals. The next list includes criteria for both feasibility study and criteria for full study:

-**Different** economical **development** : High middle income, Low middle income and Low income.

-**Similar** cultural, political and social background.

-A country **must have experienced** significant length of financial adjustment for HCD.

-**Policy makers must** be interested in and receptive to input from the study to ensure research results will be used.

-There **must already** be **database** in the country to analyze the financial aspects-HCD.

-**Multi disciplinary** research capacity.

-Relative **political stability**.

-**Reliability** of the financial data on health

4.2) Validity of the study.

There may be concern about the problems associated with the control of qualitative analysis on institutional documents, as well as on the potential problems of quantitative analysis associated with data availability to financial resources from secondary sources. The study will follow an innovative design that will deal with these problems through the integration of multiple research approaches.

Consensus exists in the evaluation literature on the need to integrate quantitative and qualitative approaches to be able to grasp the different dimensions of the impacts of a health care decentralization on financial aspects. In the same vein, the study will use all available data sources, including primary and secondary data to validate the results of the study. In general the feasibility study will provide mechanisms to assess the validity of different components of the full study.

CHAPTER 5: OPERATIONAL PLANNING OF THE STUDY

5.1-Study population.

The basic unit of analysis will be the country. For the feasibility study, 3 countries will be selected, while 6 countries will be selected for the full study (including 3 countries that were selected for feasibility study). Observations and measurements will be taken at the country, state and municipality levels.

5.2.-Sampling strategy.

The sampling strategy will take place in three stages. The first stage will involve the selection of the country. A structured convenient sample will be drawn from all the Latin American countries that have experienced health care decentralization, based on the set of selection criteria presented above. The second stage will involve the selection of 3 countries (feasibility study) and 3 more countries (full study) based in the same set of selection criteria. The third stage will involve the selection of states and municipalities within those countries. Each of the municipalities will be listed and ranked according to a set of socio-economic criteria and institutional criteria (ministry of health, social security, private institutions, NGOs). The municipalities will then be stratified, and a random sample taken from each strata.

5.3.-Sample size.

Sample size will vary at different sampling stages. For stage one the sample will be 15 countries. For stage two, the sample size will vary according to the country set selection criteria but should not exceed six countries and no less that four municipalities with health care decentralization per each country. For stage three, the sample size will be 12 units (2 municipalities per each country).

5.4.-Definition of the variables and operational definitions.

The analytical framework includes 5 sets of variables corresponding to each of the model's components. Table 1 below gives a list of type of variable, variable set, time frame and associated variables.

TABLE 1: TYPE OF VARIABLES, VARIABLE SET, TIME FRAME AND ASSOCIATED VARIABLES:

Type of Variable	Variable Set	Time Frame	Associated Variables
Health Financing	Source of Finance	1 Year Before 1 Year After	-Type of source -Structure -Origin -Allocation criteria -Total amount -Proportion by subsector -Total health budget -Others
Health Financing	Funds of Financing	1 Year Before 1 Year After	-Type of fund -Total amount by fund -Origin -Allocation criteria -Proportion by fund -Others
Health Organization	Providers	1 Year Before 1 Year After	-Type of provider -Total amount by prov. -Priority groups -Allocation criteria -Proportion by provider -Others
Health Financing and Management	Resources utilization	1 Year Before 1 Year After	-Exp. by Supporting Progr. -Exp. by investment -Exp. by level of care -Others
Health Planning and Financing	Mechanisms for resources allocation	1 Year Before 1 Year After	-National level -Regional level -Local level -Tehnical criteria -Legal and Political C. -Institutional criteria -Others

5.5.-Data collection.

The technique that will be used for this stage consists of interviews with the key personnel for each type of institution and bibliographical revision (institutional-official documents). Both the interviews and the bibliographical search will have the 6 financial fluxes formats, employed in the Latin American countries for health financial aspects and these formats will be redesigned for this purpose. With this information, the financial fluxes analysis of the health sector will be done before and after decentralization. However, during the course of main study, the instruments will be adapted and validated again with due regard to the local institutional and socio-political-cultural context.

Starting with the primary agents dynamic analysis involve in the health service financing, the financial fluxes of the sector will be identified according to 3 programmed matrix that will be designed to determine the financing fluxes, assigning the resulting economic amounts in absolute and relative frequencies according to the financial changes after decentralization.

With the information of the health sector financial dynamic, the following data for each country will be collected: origin of the funds, fluxes of the funds, normative base, legal base, destiny of the funds and the technical base for new mechanism of resources allocation (epidemiologic-demographic-economic-legal-political-institutional).

In a consensus meeting, the contrasting results will be confronted to identify the advantages and shortcomings of the different financial changes for health care decentralization , in such a way that from these results a supporting tool could be generated ("decision rule") for the evaluation and decision making in terms of follow-up and adjustments to the financial policies in the context of decentralization.

5.6.-Data analysis.

The data analysis includes both: qualitative analysis(C) and quantitative analysis (Q). It will closely follow the research hypotheses and the objectives. It will have six steps:

-analysis of the financial indicators before decentralization (C and Q data).
-analysis of the main financial changes during implementation of decentralization (C and Q data).
-assessment of the impact and effects according to the type and pattern of decentralization (C and Q data).
-analysis of weakness and strengths on financial changes and decentralization per each country (C and Q data).
-analysis of integration and confrontation of results among countries.
-Integration and discussion of results

5.7-Timetable.

5.7.1: Feasibility study. Preliminary workplan (September 97-May-98).

-Selection of countries	September-97
-Selection of sources of information	September-97
-Selection of key personnel to interview	September-97
-Design-redesign of instruments	October-97
-Methodology standardization	Octoer-97
-Field work: Country A	November-97
-Field work: Country B	November-97
-Field work: Country C	December-97
-Data reliability and validity	January-98
-Data processing	February-98
-Analysis/interpretation (Country results)	February-98
-Analysis/interpretation (Three countries)	March-98
-Consensus meeting-conclusion and discussion-	April-98
-Final Technical Report	May-98

5.7.2: Full Study. Preliminary workplan (June 98 to June 2000).

-Planning workshop for the full study
-Selection of the countries
-Selection of research teams in the countries
-Revision of the model, methodology and measurement instruments by the country team.
- Coordination workshop to standardize and harmonize country projects.
-Field work.
-Preparation of the country reports.
-Integration and confrontation the country reports
-Drafting the Integral report.
-Seminar to discuss the use and dissemination results.

5.8.-Ethical review.

The study will involve the collection of secondary data and survey in order to acquire information of institutional variables on financial aspects and decentralization. In addition to obtaining consent and authorization from appropriate authorities to conduct the study, the study team in each country will seek and obtain consent from the authorities and personnel to be interviewed. Finally, the anonymity of all information will be respected.

CHAPTER 6: PROJECT COORDINATION.

If the proposal is aproved, IDRC could be responsible for the overall coordination of the project. A multi-donor consortium will be set up to advise upon and approve the selection of the countries and the country budgets. In addition, the current informal consultation group, which helped IDRC develop the research initiative, will be retained, with some minor modifications, for future technical assistance on matters such as review of country proposals, to liaise with the country research teams, to provide expertise during the implementation of country projects, and to provide assistance in the writing of country reports and the final project report.

CHAPTER 7: EXPECTED OUTCOMES AND DISSEMINATION OF RESULTS

7.1.-The impact of this study will be determined by the following:

-There will be a financial information baseline that will allow for a rational decision making in the follow-up of HCD, and in the efficient and equalitarian use of the financial resources that would be assigned to the sector.

-There will be identification of the basic problems in financial matters that each country is facing in the process of HCD, thereby promoting the feed-back among countries.

-From the knowledge of the strengths and weaknesses of each country, a working tool (decision rule) will be generated for the analysis and solution of the difficulties that could have arise in the financing of the health services in the process of HCD.

7.2-Outputs for short-term:

-Indicators and comparative analysis for financing funds and financial sources for HCD.

-Indicators and comparative analysis of financial amounts and final destiny of financing funds by type of institution regional level for HCD.

-Methodological Instruments: Mechanisms for resources allocation in the context of HCD.
Tool from strengths and weaknesses in each country, Decision rule for financing dynamics and adjustments for HCD. Decision rule for resources allocation mechanisms at regional level.

-Conceptual Instrument: New framework for the analysis, evaluation and monitoring of the financing dynamic and resources allocation mechanism in the process of HCD.

7.3-Outputs for midle and long-term:

Utilization of results and new tools for the HCD assess and continuity:

-Utilization of decision rule for financing dynamics.

-Utilization of decision rule for resource allocation mechanisms at regional level.

-Follow-up, monitoring and evaluation of health financing policies and resource mechanisms in the context of HCD.

7.4-Dissemination of results.

The project will hold national and international dissemination workshops. The inputs will be:

Working papers. Technical papers to discuss with researchers, politicians, government official and NGOs. Policy papers to discuss at national and regional level. Data base in economic evaluation. New instruments-tools for policy design, analysis and assess financial changes for health care decentralization. Book highlighting the project's research results will be published for wider dissemination.

CHAPTER 8: BUDGET

no justification

8.1.) Feasibility study (PRELIMINARY BUDGET).

Concept	Total Cost (CAD.)	Grant IDRC (CAD)	Grant Others (CAD)
Personnel:			
-Coordinator	15000.00	5000.00	10000.00
-Under-coordinators	14000.00	14000.00	
-Technical assistant	10000.00	5000.00	5000.00
-Assistant research.	6000.00	6000.00	
-Administrative assist	4000.00	4000.00	
-Clerical support	3000.00	2000.00	1000.00
-Traveling expenses	8000.00	8000.00	
-Office materials and computing materials	4000.00	2000.00	2000.00
-Field work material	2500.00	1000.00	1500.00
-Tel, fax and mail	4000.00	4000.00	
SUBTOTALS	**70500.00**	**51000.00**	**19500.00**

IDRC (grant) :.....	**51,000.00**
OTHERS (grant):.....	**19,500.00**
TOTAL BUDGET:.....	**70,500.00**

8.2.) Full study (BUDGET BREAKDOWN).

-Research expenses.....	200,000.00
-Dissemination.....	10,000.00
-Consultants.....	60,000.00
-Travel.....	20,000.00
TOTAL BUDGET.....	**290,000.00**

SUBTOTAL BOTH STUDIES.....	**360,500.00**
ADMINISTRATIVE COSTS (10%).....	**36,000.00**
GRAND TOTAL.....	**396,500.00**

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Appendix 2

Common grounds and potential for cooperation between ASPR and MIMAP PIs.

INTERNATIONAL DEVELOPMENT RESEARCH CENTRE

COMMON GROUNDS AND POTENTIAL FOR COOPERATION BETWEEN ASSESSMENT OF SOCIAL POLICY REFORM (ASPR) AND MICROIMPACTS OF MACROECONOMIC AND ADJUSTMENT POLICIES (MIMAP).

Armando Arredondo.

Ottawa. August, 1997.

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1) Introduction and statement of the problem.

This essay attempts to respond to a problem that has surfaced around two IDRC program initiatives: the Micro Impacts of Macroeconomic and Adjustment Policies Initiative (MIMAP), and the Assessment of Social Policy Reforms (ASPR). This problem can be defined through the following questions: To what point do these programs overlap, duplicate, supplement or conflict with each other? Are there similarities and differences between the two? From these two questions a third one arises, which is central to this essay: Is it possible to identify a convergence point, a common ground where both initiatives could interact to advance in the generation and application of knowledge to social development policies?

To approach this problem, and to attempt to answer these questions, a review of the research projects and the working documents of both program initiatives was undertaken. The methodology used was based on the analysis of documents from each program and on interviews, directed through a questionnaire, with members of each working team. The results are given in the context of the findings from these interviews and from the review of the working documents. These results attempt to identify, in a general manner, the characteristics of each program initiative.

Based on these results, which determined that each program is a component in the development of an analysis framework, it is proposed that an integral reference framework should be produced to be used as a common tool for the study of social politics in developing countries from the perspective of each of the two program initiatives. For this purpose, different conceptual and methodological approaches are proposed, with the objective of defining a common ground for cooperation.

The last section of this essay includes discussion and conclusions, reexamining the different approaches that could integrate the proposed framework. The discussion and conclusions have as their basic objective to set the particular parameters that each approach could take into account if the potential development of this proposal is accepted. It is important to emphasize the framework itself is not under discussion, but rather its potential development. At the end, this document advances some conclusions regarding some of the expected benefits that both IDRC program initiatives could accrue from a framework of collaboration, complementarity and interaction. This is advanced as a proposal to strengthen the contribution of IDRC to social development.

2) Objective.

Identify common areas, at the conceptual and/or methodological levels, with potential for technical interaction between the two IDRC program initiatives: ASPR and MIMAP.

3) Methodological Considerations.

The development of this essay was based on the review of documents from each program and on interviews with members from both working teams. The interviews were intended to take place with all team members based at the Ottawa office. However, due to working engagements in foreign countries, only 4 members of each team were interviewed (for a total of 8, equivalent to 80% of the participants in Ottawa for each program). The interviews were based on a questionnaire with both opened and closed questions, including six main indicators (see Annex 1). These indicators refer to: the subject of the study; the study methodology; the conceptual framework and working disciplines; the analysis level; the evaluation subject; and the possible interaction between both teams.

To supplement and validate the information obtained through the interviews, a document review was undertaken, taking into account as a guide the same indicators used in the interviews. This review included a total of 16 documents (see Annex 2): 10 research projects (5 from each program), and 6 conceptual or methodological working documents (3 from each program).

4) Results.

The results from the document review and from the interviews, indicate that both program initiatives approach from different evaluation perspectives the study of social policies oriented to achieve sustainable and equitable development. While the MIMAP approaches the problem through the evaluation of the impact of macroeconomic adjustment policies on social policies, the ASPR focus is on evaluation through the process of analysis, design, implementation and evaluation of the social policies themselves.

Although both programs include the evaluation of the process and the results (and much more rarely, inputs) in some studies, it could be said the MIMAP focuses on the results as feedback for the process, while the ASPR focuses on the process as feedback for the results and, occasionally, for the evaluation of the inputs. It is important to emphasize that, in most of the studies reviewed for each program, the explicit and detailed analysis of health, education or social safety services (employment, environment, recreation) was not addressed. This is remarkable, as the development of knowledge regarding the evaluation of social policies should take into account its three fundamental components: inputs, process and results.

At the conceptual and methodological levels, as well as regarding the typical proposals of each program initiative, there are other important differences which, in turn, supplement an integral analysis of the subject under study. These differences can be determined according to the indicators included in the questionnaire and in the document review guide. While these indicators could not be clearly identified in some of the proposals, it was nevertheless possible to do so in most. There are particular details in each program that may create confusion regarding its components; however, in an attempt to identify in a general manner the explicit character of each program we can state that:

In general terms, MIMAP is basically focussed on analysing the impact of adjustment policies through the study of several social development result indicators. For this purpose it focuses on the study of results without getting involved in a detailed study of the process and, least of all, of the inputs. It uses the result analysis as feedback for the process, but it does not directly approach the process itself and, in general, it does not take inputs into account. Although it advocates the involvement several working disciplines, the economic perspective tends to dominate. It takes other disciplines into account but does not assign to them the same analytical weight. The analysis of the different problem variables basically takes place at the macro and micro levels, without dealing with the meso level. The effect is what matters. That is to say, what took place at the level of social policies as a result of macroeconomic adjustments. Therefore, in most projects, the method and the techniques are mostly oriented towards quantitative analysis through the use of econometric models. Some result indicators are identified, generally from a technical perspective, taking into account the population point of view only in one of their studies.

The ASPR program initiative is basically focussed on the evaluation of social policies through the study of the "how" and the "why" of those social policies. Therefore, the focus of this initiative is studying the process without engaging in any detailed analysis of the results or the inputs. It uses the process analysis as feedback for the results, but it does not directly deal with the results themselves nor does it take inputs into account. Regarding the working disciplines, it proposes and implements a multidisciplinary analysis weighted towards the social sciences. The analysis of the problem variables basically takes place at the macro and meso levels, without dealing with the micro level. The process is what matters. That is to say, how, why and through what means were the social policies defined within the context of government reforms. In most projects the method and the techniques are mostly oriented towards qualitative analysis and only to a lesser degree towards quantitative analysis. The social policies process is identified only from a technical perspective. None of the studies takes into account the population point of view.

In both programs temporality and standardization problems seems to be present, affecting the use of comparative results. The standardization problem refers to the study methods and the indicators to be obtained. The temporality problem refers both to the initiation of the program as well as to the evaluation time frames used by each study proposal in different regions or countries.

At the conceptual level it is not easy to identify a clear and precise definition regarding concepts common to both programs. What are policies? What are social policies? What are adjustment policies? Which policy components are evaluated: plans, programs or their strategies ? What is understood by efficiency, equity and effectiveness in the context of social policies? All these concepts are used in both programs basic documents as well as in the different proposals. All documents give examples of equity, efficiency, adjustment policies, etc. But there are no definitions.

5) The proposal: Towards the development of a common and integral analysis framework.

As a common working ground, where both programs could interact and supplement each other according to the IDRC philosophy, a proposal is made for an integral reference framework, based on a systemic focus, taking into account two of the main objectives for studying social policies oriented towards the promotion of social development: the production of knowledge relevant to decision makers, and the development of reasonable arguments allowing the transformation of information into recommendations for government activities affecting human development. This framework is proposed to integrate empirical findings, obtained from research funded by either program initiative, as well as to provide feedback for their objectives and facilitate, from an integral point of view, the use of research results in the generation of recommendations and activities pertaining social policies.

This reference framework will not only facilitate approaching the problem under study and using research results in an integrated manner, but will also identify in which section of the problem analysis does each research project fit, avoiding, through greater clarity, overlapping or duplication of projects. Ideally, the proposal to be developed should be based in the results of the research projects of each program initiative, creating a reference framework supported by their empirical results. For this purpose, the main approaches identified to develop the proposed framework include the following aspects:

5.1) Conceptual issues

5.1.1) The definition of the evaluation subject
5.1.2) The working disciplines
5.1.3) The basic concepts

5.2) Methodological isuues

5.2.1) The evaluation perspectives
5.2.2) The evaluation methods
5.2.3) The analysis levels
5.2.4) The methodological difficulties for comparative analysis

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6) Discussion and conclusions.

Attempting to respond to the questions and objective identified for this essay, the results allow stating that the two programs are different. Although they occasionally appear to overlap or duplicate each other, an analysis of their main components indicates that they are supplementary to each other. This analysis also indicates possible convergence areas for developing a common framework, with different conceptual and methodological approaches, which would allow studying social policies in a systemic and integral manner. Therefore, the proposed approaches will be reexamined in this section to discuss which should be the main concept to be developed under each of them. On the other hand, the conclusions include general and specific considerations based on the contents of the essay, and basically focussed towards the identification of the expected benefits to be obtained from the development of a common analysis framework for both initiatives.

Regarding the subject under evaluation, the idea would be to develop conceptual parameters. These parameters, through a systemic approach, may allow to identify and define the approach to the study subject through the inputs, the process and/or the results. Identifying from the beginning which is the systemic component of the policy being evaluated also allows identifying the appropriate use of the results. On the other hand, as MIMAP focuses on results, ASPR on the process, and both only marginally on inputs, this approach could be used as a guide for the integration of research results from both initiatives, and particularly for the analysis and transformation of these results into recommendations.

Regarding the working disciplines, regardless of the program initiative, the proposal would try to define, in an explicit way, the conceptual and methodological elements that different disciplines can offer for the analysis of social policies. A multidiciplinary approach to the issues under study would be explicitly made at this level.

In relation to the main concepts used, or rather, the concepts that both initiatives have in common, we would try to define from the beginning what is meant by policies, social policies and adjustment policies, as well as to define when are we dealing with a plan, a program, or a strategy as a component of a social policy. In the context of social policies, we would reexamine the concept of human development and we would clarify the concepts of equity, efficiency and effectiveness. It would also be necessary to emphasize the nominal and the operational definitions of these last three concepts in the evaluation of social policies.

Regarding the evaluation perspectives, one should start from the fact that the evaluation of any policy should ideally include three analysis perspectives depending of who participates in their design, implementation, monitoring and evaluation. This approach should be included to clearly determine which is the perspective used by each program initiative and which perspectives are absent, allowing the integration and utilization of results from both programs. Ideally, the three perspectives should be taken into account, from the initial problem planing phase to the planning of the methodology and to the results analysis. These three perspectives are: a technical perspective (researchers and evaluators), a supplier perspective (decision makers), and a consumer perspective (the population

demanding and using the services).

With respect to the evaluation methods, we propose to clearly and precisely identify the analysis methods used in the evaluation of social policies and their advantages and disadvantages in the evaluation of results. Therefore, it would be necessary to emphasize, in the reference framework, that the inclusion of quantitative and qualitative evaluation methods will not only increase knowledge about the problem being studied, but will also result in a more integrated evaluation. The identification of both analysis methods, and their different evaluation tools, should be obvious. The advantages and disadvantage of their use in regards to the study of any social policies problem should be equally obvious. However, this is not the case. In addition, there is a degree of epistemological confusion that unavoidably interferes with the identification and proper use of the evaluation methods applied to any social policy.

The context in which the social policies take place would allow identifying the micro, meso and macro variables that determine or intervene in regards to inputs, processes and policy results. It is important to explicitly identify the variables involved to determine, based on the results, at which context level can action take place and at which levels it would not be advisable to take any action. In other words, a fundamental requirement to be able to identify the most cost effective actions is to be clear and explicit regarding the analysis level of the variables under study and their results.

Regarding the comparative analysis of the results, it would be advisable to design a comparison mechanism, methodologically valid and technically feasible, that will allow to take maximum advantage of the results. This approach should take into account, among other issues, the problem of temporality in both retrospective as well as prospective evaluations, the methodological and technical procedures, and the standardization of evaluation indicators. Although comparative analysis is mentioned as an important goal, both program initiatives have projects with similar objectives, similar evaluation techniques and methods, but different indicators.

The proposed common framework offers benefits for each program and for the interaction of both programs. This framework could offer elements to face the challenge (from either program perspective or from the interaction of both), on how could IDRC, through both program initiatives, provide advise and support for social development in an equitable, efficient and effective manner while being also effective and efficient in the development of knowledge and in its application into practical, coherent and pertinent recommendations for social policy decision makers in developing countries.

On the other hand, the benefits that can be expected within each program initiative are directly related to the precision and clarity of the concepts, methods and techniques to be used in new research projects or in providing feedback for projects already started. However, it would be particularly useful, through the common use of conceptual and methodological elements, to design complementary and integral mechanisms for using the research results produced to date by each of the two initiatives.

The results of this essay are a first approach to this problem and were obtained through a fast evaluation methodology. It is important to emphasize that we left out, on purpose, the debate between social scientists and economists, as the detailed epistemological study that would be required would not be conductive to solving the problems we perceive between both program initiatives. It should also be emphasized that the development of this essay was a trial and error process determined by conceptual and methodological limitations as well as by cost and time. This essay is not exceptional and can be appreciated from different points of view: as a simple exercise in abstraction, as a misguided effort, as an advance in regards to the subject under study or, at best, as a pertinent contribution for approaching and attempting to find solutions to the problems under study.

Finally it is important to stress that this document advances only a possible solution but it is not the only one. To provide follow up for this document it should be determined if this proposal is the most adequate in regards to the definition of the problems, the methodological approach, and the analysis and result interpretation. Therefore, this essay could follow any of the following three paths: it could be filed as just one more working document that, regardless if it has or has not achieved its objectives, did at least comply with an institutional procedure; it could receive critical feedback without follow up; or it could receive critical feedback, and be subject to restructuring and follow up until it becomes better suited to achieve its objectives.

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APPENDIX 1: COMMON GROUNDS FOR COOPERATION BETWEEN ASPR and MIMAP.

According to your experience as P.I. team member of PsIs (MIMAP or ASPR) could you answer the following questions ?

MIMAP_____ ASPR_____

1) What is the main subject upon which the PI focuses ?

_____

2) In relation to the various disciplines of study, the P.I. involves (please list disciplines) ?

One or two disciplines_____ Multidisciplinary_____

_____ _____

_____ _____

_____

_____

_____

_____

3) In relation to the methods, the program focuses primarily on:

Qualitative___ Quantitative_____

4) In relation to the level of analysis, the program focuses primarily on:

Micro____ Meso____ Macro____

5) In relation to assessment, the program focuses primarily on:

Inputs___ Process___ Outcomes____

6) Are there any interaction betwen ASPR and MIMAP ?

Yes____ Not_____ Don't know____

-If so, how would you characterize these ?_____

_____

7) Any comments_____

_____

APPENDIX 2: LIST OF DOCUMENTS REVIEWED ON ASPR AND MIMAP PI.

RESEARCH PROJECTS:

MIMAP.

1.-THE MICRO IMPACTS OF MACROECONOMIC AND ADJUSTMENT POLICIES (MIMAP). IDRC PROGRAM INITIATIVE. PI PROSPECTUS.

2.-MACROECONOMIC ADJUSTMENT POLICIES. HEALTH SECTOR REFORM AND THE IMPACT ON ACCES TO, UTILIZATION AND QUALITY OF HEALTH CARE.

3.-MONITORING MICRO IMPACTS OF MACRO AND ADJUSTMENT POLICIES IN NEPAL.

4.-THE MACRO IMPACT OF MACRO ECONOMIC ADJUSTMENT POLICIES- A CASE STUDY OF PAKISTAN.

5.-THE IMPACT OF MACROECONOMIC AND ADJUSTMENT POLICIES ON THE ENVIROMENT (PHILIPPINES).

ASPR.

1.-ASSESMENT OF SOCIAL POLICY REFORMS. AN IDRC PROGRAM INITIATIVE. PROSPECTUS. A THREE-YEAR PLAN OF ACTION FOR PROGRAM IMPLEMENTATION.

2.-SOCIAL POLICY DECENTRALIZATION: A REGIONAL PERSPECTIVE.

3.-EDUCATION, EQUITY AND ECONOMIC COMPETITIVENESS IN THE AMERICAS.

4.-DECENTRALIZATION AND SOCIAL POLICIES.

5.-COMPARATIVE HEALTH CARE POLICIES (LATIN AMERICA).

WORKING PAPERS:

MIMAP

1.-MONITORING SYSTEMS FOR POVERTY TRACKING. CELIA REYES. SECOND ANNUAL MEETING OF MIMAP. MAY-1997.

2.-THE MIMAP EXPERIENCE TO DATE AND FUTURE DIRECTIONS. ROHINTON MEDHORA. PRELIMINARY VERSION. IDRC.

3.-MONITORING ADJUSTMENT AND POVERTY: DEVELOPING A POVERTY MONYTORING SYSTEM IN BANGLADESH. MUSTAFA K. MUJERI.SECOND ANNUAL MEETING OF MIMAP. MAY-1997.

ASPR

1.- DECENTRALIZATION AND SOCIAL POLICIES IN LATIN AMERICA. FINAL REPORT ON THE WORKSHOP. PREPARED BY MARIO TORRES. IDRC, 1994.

2.-REPORT ON MID-PROJECT WORKSHOP ON DECENTRALIZATION IN THE SOCIAL SECTOR: AN ANALYSIS OF PROCESSES AND OUTCOMES (ASIA). IDRC. 1996.

3.-THE CONTENTS OF DECENTRALIZATION: CONCEPT, OBJECTIVES, PROS AND CONS, AND CHALLENGES. ALFREDO RODRIGUEZ. IDRC.

COMMON GROUNDS FOR COOPERATION BETWEEN ASPR and MIMAP.

According to your expieirence as P.I. team member of PsIs (MIMAP or ASPR) could you answer the following questions ?

MIMAP X ASPR _____

1) What is the main subject upon which the PI focuses ?

Links between, and impacts of economic reforms (macroeconomic policies) on welfare

2) In relation to the various disciplines of study, the P.I. involves (please list disciplines) ?

One or two disciplines _____

Multidisciplinary X
- multi in economics (macro, finance, modelling...
- environment
- social sciences (sociology) in
- health "

3) In relation to the methods, the program focuses primarily on:

Qualitative X Quantitative X

4) In relation to the level of analysis, the program focuses primarily on:

Micro X Meso ____ Macro X

5) In relation to assessment, the program focuses primarily on:

Inputs ___ Process ___ Outcomes X

6) Are there any interaction betwen ASPR and MIMAP ?

Yes X Not _____ Don't know ____ PS, trip reports,

-If so, how would you characterize these ? exchange of information when issues are similar

7) Any comments could be improved in terms of defining entry points

COMMON GROUNDS FOR COOPERATION BETWEEN ASPR and MIMAP.

According to your expieirence as P.I. team member of PsIs (MIMAP or ASPR) could you answer the following questions ?

MIMAP_____ ASPR✓_____

1) What is the main subject upon which the PI focuses ?

approaches to social policy reform

2) In relation to the various disciplines of study, the P.I. involves (please list disciplines) ?

One or two disciplines_____ Multidisciplinary_____

- Health
- [illegible]
- [illegible]

3) In relation to the methods, the program focuses primarily on:

Qualitative___ Quantitative✓____

4) In relation to the level of analysis, the program focuses primarily on:

Micro✓___ Meso____ Macro✓___ (Policy)

5) In relation to assessment, the program focuses primarily on:

Inputs___ Process✓___ Outcomes✓___

6) Are there any interaction betwen ASPR and MIMAP ?

Yes____ Not_____ Don't know✓___

-If so, how would you characterize these ?_____

_____

7) Any comments_____

_____

COMMON GROUNDS FOR COOPERATION BETWEEN ASPR and MIMAP.

According to your expieirence as P.I. team member of PsIs (MIMAP or ASPR) could you answer the following questions ?

MIMAP ✓ ASPR_____

1) What is the main subject upon which the PI focuses ?

The micro-level impacts of macroeconomic and adjustment policies

2) In relation to the various disciplines of study, the P.I. involves (please list disciplines) ?

One or two disciplines_____

Multidisciplinary ✓

Economics
Health
Nutrition
Environment
Sociology

3) In relation to the methods, the program focuses primarily on:

Qualitative___ Quantitative ✓

4) In relation to the level of analysis, the program focuses primarily on:

Micro ✓ Meso____ Macro____

5) In relation to assessment, the program focuses primarily on:

Inputs___ Process ✓ Outcomes ✓

6) Are there any interaction betwen ASPR and MIMAP ?

Yes ✓ Not_____ Don't know____

-If so, how would you characterize these ? Both PIs are involved in the assessment of the impacts of policy reforms.

7) Any comments_____

COMMON GROUNDS FOR COOPERATION BETWEEN ASPR and MIMAP.

According to your expieirence as P.I. team member of PsIs (MIMAP or ASPR) could you answer the following questions ?

MIMAP ✓ ASPR_____

1) What is the main subject upon which the PI focuses ?

linking "micro" to "macro" via a wide ranging poverty monitoring exerc and economic modelling that measures policy impacts at the household level.

2) In relation to the various disciplines of study, the P.I. involves (please list disciplines) ?

One or two disciplines_____

Multidisciplinary ✓

Economics
Political Economy
Statistics
Nutrition Science
Environmental Studies
Sociology

3) In relation to the methods, the program focuses primarily on:

Qualitative___ Quantitative ✓

4) In relation to the level of analysis, the program focuses primarily on:

Micro ✓ Meso____ Macro ✓

5) In relation to assessment, the program focuses primarily on:

Inputs___ Process___ Outcomes ✓

6) Are there any interaction betwen ASPR and MIMAP ?

Yes ✓ Not_____ Don't know____

-If so, how would you characterize these ? Specific, on 2 topics: decentralization, and the MAPs - health sector nexus.

7) Any comments These contacts are at an early stage, but should develop as specific activities move forward.

COMMON GROUNDS FOR COOPERATION BETWEEN ASPR and MIMAP.

According to your expieirence as P.I. team member of PsIs (MIMAP or ASPR) could you answer the following questions ?

MIMAP_____ ASPR ✓

1) What is the main subject upon which the PI focuses ?

Assessment of various dimensions of social policy reforms

2) In relation to the various disciplines of study, the P.I. involves (please list disciplines) ? across sectors.

One or two disciplines_____

Multidisciplinary_____

political science
education
(health) economics
sociology
information science
development studies

3) In relation to the methods, the program focuses primarily on:

Qualitative ✓ Quantitative ✓

4) In relation to the level of analysis, the program focuses primarily on:

Micro ✓ Meso ✓ Macro____

5) In relation to assessment, the program focuses primarily on:

Inputs ✓ Process ✓ Outcomes ✓

6) Are there any interaction betwen ASPR and MIMAP ?

Yes ✓ Not_____ Don't know____

-If so, how would you characterize these ? Minimal. Occasion consultation, information sharing. Overlapping team membership.

7) Any comments_____

COMMON GROUNDS FOR COOPERATION BETWEEN ASPR and MIMAP.

According to your expieirence as P.I. team member of PsIs (MIMAP or ASPR) could you answer the following questions ?

MIMAP_____ ASPR ✓

1) What is the main subject upon which the PI focuses ?

Social policy reforms

2) In relation to the various disciplines of study, the P.I. involves (please list disciplines) ?

One or two disciplines_____

Multidisciplinary_____

Health
Educational Com
Social policy
Sociology
Political Sciences
Economics

3) In relation to the methods, the program focuses primarily on:

Qualitative ✓ Quantitative_____

4) In relation to the level of analysis, the program focuses primarily on:

Micro____ Meso____ Macro ✓

5) In relation to assessment, the program focuses primarily on:

Inputs___ Process ✓ Outcomes____

6) Are there any interaction betwen ASPR and MIMAP ?

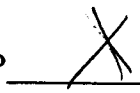
Yes ✓ Not_____ Don't know____

-If so, how would you characterize these ? very limited at this Stage

7) Any comments I believe That there should be more constructive thinking on How ASPR1 and MIMAP could collaborate

COMMON GROUNDS FOR COOPERATION BETWEEN ASPR and MIMAP.

According to your expieirence as P.I. team member of PsIs (MIMAP or ASPR) could you answer the following questions ?

MIMAP  _____ ASPR_____

1) What is the main subject upon which the PI focuses ?

_____

2) In relation to the various disciplines of study, the P.I. involves (please list disciplines) ?

One or two disciplines_____ Multidisciplinary_____

_____ _____

_____ _____

_____

_____

_____

_____

3) In relation to the methods, the program focuses primarily on:

Qualitative___ Quantitative_____

4) In relation to the level of analysis, the program focuses primarily on:

Micro____ Meso____ Macro____

5) In relation to assessment, the program focuses primarily on:

Inputs___ Process___ Outcomes____

6) Are there any interaction betwen ASPR and MIMAP ?

Yes____ Not_____ Don't know____

-If so, how would you characterize these ?_____

_____

7) Any comments_____

_____

To: Armando Arredondo@PB DGP@IDRC CRDI
Cc:
Bcc:
From:
Subject: questionnaire
Date: Monday, August 25, 1997 14:56:59 EDT
Attach:
Certify: N
Priority: Normal
Defer until:
Expires:
Forwarded by:

I had a look at the questionnaire but did not send it back to you. I don't think it is possible to identify further opportunities for collaboration between PIs through such an exercise, given the way we work. Moreover, the definition of some of the terms isn't explicit (e.g. "micro", "meso"), and/or the terms don't provide meaningful categories in relation to ASPR (e.g. "qualitative" vs. "quantitative").

Best of luck in Montreal, keep in touch.

Appendix 3

Financial indicators for health care decentralization in developing countries. A framework for analysis

FINANCIAL ISSUES FOR HEALTH CARE DECENTRALIZATION IN DEVELOPING COUNTRIES: A FRAMEWORK FOR ANALYSIS.

WORKING PAPER-DRAFT PROPOSAL. PLEASE DO NOT CITE

Armando Arredondo

INTRODUCTION.

Decentralization is one of the principal elements of health sector reform in a wide range of developing countries. It is increasingly recognised, both national and international levels, that management, planning and policy functions in the health sector may be carried out more efficiently and effectively, if they are decentralized. Unfortunately, many decentralization processes are not implemented as they fail to overcome the strong forces in favour of centralization. There is also a growing concern that decentralization has failed to achieve the objectives for which it was introduced and can indeed have effects that limit health sector development (Cheema-Rondinelli, 1983. Collins, 1994).

The relationship betwen decentralization and financial changes for health care reform in developing countries is complex. Decentralization is a term which is used to refer a wide range of organisational structures and processes, each of which may affect health systems differently. Health financing is an equally complex concept, which has many diferent aspects, each of which can be influenced by decentralization in diferent ways. The relationship betwen specific form of decentralization, sources of finance, and aspects of health systems performance may be indirect or obscure, and be complicated by the fact decentralization is only one of many sets of factors affecting the functioning of health systems (Collins, 1996).

Although there has been a growing literature on general decentralization of public administrations, usually examining in general terms financial flows, there has been remarkably little concrete and research on the forms and impact of decentralization in the health sector and on the details to respect the effectiveness and efficiency in the financial changes and the new resources allocation mechanisms. The dominant publications are largely conceptual and descriptive of single cases, with some recomendations based on expert opinion. There has been litle systematic develop on methods and conceptual approaches for the analysis of financial changes and decentralization.

What does come from this research, however, are disturbing case studies of the problems of decentralization (Campos, 1995). Many of the cases , largely project evaluations funded by donors, show that poorly designed and implemented programmes of decentralization do not reach expected objectives, and may indeed make matters worse. Of particular concern is evidence of local decisions in favour of curative higher cost services, putting preventive progammes at risk (Holley, 1995).

Also, most of the research to date has focused on the public administration approach and very little has evaluated the regulated market approach. One of the best synthesis of research utilizing the public administration approach is by Mills and colaborators, whose overview of decentralization issues

shows far case studies and expert opinion can go (Mills et al, 1990). It is an excellent summary of the state of art and hols good advice. It, however, does not provide sufficient empirical evidence to back up most of its analysis. This is not a fault of the overview, it only demostrates that not enough good research has been done.

A central problem is that few research projects have developed systematic definitions, conceptual framworks and consistent methodologies to produce consistent, valid and reliable results for comparative studies among countries. A major problem is the difficulty of developing countries criteria for evaluating decentralization that can go beyond the general preferences of the "eye of the beholder". Community level officials and advocates tend to prefer greater authority and responsability -if it comes with access to resources- and central level officials and advocates tend to resist giving up control of operations and resources.

Associated with this problem, is a key methodological problem of isolating decentralization effects from other system changes which migth influence outcome and output variables. When decentralization occurs, there are usually short term transaction costs, lags in implementation and changes in other independent variables that complicate measurement and atribution of dependent variable change (Bossert,1996).

Although the existing research may have informed government officials and international technical assistance, it is not clear that the advice is consitent enough to be persuasive. Most decentralization programmes in the last twenty years which have followed the public administration approach have had little impact on transfer of power away from the central national offices. It is decentralization that was been motivated by an ideological commitment to market oriented public policy that may have had more succes in transferring power. Currently, major donors for international development, whose policies have been informed by particular ideological orientations, are strongly encouraging developing countries to adopt decentralization (Bossert, 1996). These decentralization policies have, however, not been informed by proof of effectiveness, equity, and efficiency in the changes for financial aspects, particularly with the resources allocation in the context of health care reform initiatives in developing countries..

On the other hand, many developing countries have tried to decentralize their health care systems in different ways, with different results, including strengths and weaknesses for each country. The results are highly related to the changes in the mechanisms for financial resources allocation, and specially with the new financing dynamics for health services in the context of health care reform. The financing study of health care decentralization quantifies the amounts of resources involved and it analyses the sector dynamics, its opportunities and sufficiency. At the same time, it intends to mobilize and reassign resources within the system at national and regional level. The objective of the policy is to assure that the impact of the health expenditure is optimal. These goals suggest the need to adequate resource collection and resource allocation for decentralization and requires as a basic input several micro and macroeconomics indicators that identify and monitor the financial problems and the need of change, as well as the opportunities so that this change achieves the maximum level of equity, quality and efficiency.

In this context, the framework proposed in this manuscrit, include conceptual and methodological aspects to analyse the financial changes when health care decentralization process is implemented in the context of health care reform for developing countries.

BACKGROUND.

Health care decentralization is a complex and multifaceted issue in developing countries. Analysis of recent attemts at decentralization requires an understanding of the contradictory forces at work within the political systems, and particularly the bureaucracies in which strong centralizing tendencies coexist with particular forms of bureaucratic decentralization. Centralizing tendencies remain predominant, and decentralizing forces both are caused by and serve to reinforce them.

According to the analysis of health financing in some developin countries (PAHO, 1995), the method of allocation of national government revenue can vary from grants that are not earmarked for any purpose (often termed "block grants") to those that are closely tied to particular activities and expenditures. At one end of the spectrum, a fixed percentage of national revenues may be earmarked for local government and divided between local governments according to some measure of their "need", possibly including some requirement for the local authority itself to raise a certain minimum sum. For instance, in some developing countries a fixed percentage of the statutory allocation from federal level to other levels government is earmarked for local government, as is a minimum proportion of state revenue. One quarter of this funds is divided equally between local authorities; the remaining 75% is distributed according to population (Gilson, 1995).

A less permissive method is to tie grant to particular local functions. For example, in some countries the expansion in rural health services is funded from the national level . The proportion of the total available for health is first decided between the National Planning Offices and the Ministries of Health, and the funds are then divided between provinces on the basis of various indicators of "need". Finally, each province and the health authorities discuss how the provincial allocation will be spent (Gilson 1995).

A similar method can be used for the allocation of recurrent and capital funds to deconcentrated local administrations of ministries of health. In many countries it is customary for allocations to be made on the basis of past allocations, thus permitting inequalities between districts to persist or even worsen. This approach can be replaced by resource allocation formulate that reflect the "need" of each district (McPake, 1991). At the least, size of population should be entered into the formula. Further refinements could be to weigh the population by indicators of health service need, for instance mortality and morbidity rates, or of socioeconomic status, for instance, average local per capita income.

The inadequacy of financial resources and the inability to allocate and expand them effectively were noted in evaluations of health care decentralization in nearly every developing country. The lack of

independent sources of revenue weakened the local organizations ability to carry out its tasks. The dependence on central government grants kept the local organizations under the control of the central bureaucracy. Even in countries which devolved revenue raising powers to local governments, localities remain dependent on central funding for most of their activities. After more than a decade of devolution in some countries the provincial councils still receive about 55-65 percent of their revenues from central governments grants (Harley, 1995).

A detailed study of decentralization in developing countries stressed financial problems of the provinces and their impacts on decentralized administration. The survey revealed that the amounts of financial resources transferred to the province through the budget were far below the minimum amounts needed to implement functions transferred from the central ministries. The Ministry of Finance cut the budgets requested by the province's executive councils by 50 percent in some years. The provinces were never reimbursed for minor public works expenditures made during previous fiscal years. At the same time, the central government increased the amounts that the provinces would have to collect in local taxes to levels far beyond their capacity. The result was a severe shortfall in revenues that constrained the executive council's ability to provide services or undertake development projects (Gilson, Mills, 1995). The revenue base is simply too small to provide adequate tax resources. The forms of taxation that can be imposed on subsistence economies are extremely limited.

Shortages of skilled personal and financial resources have also undermined decentralization in Latin America. Because they lack financial resources, the local governments have difficulty covering their basic operating expenses, training their personnel, making organizational improvements, obtaining technical assistance, and expanding the range and quality for health services. Harris notes (1983): "Their limited funds make it impossible for them to improve their administrative capacity. Their limited administrative capacity discourages the allocation of new functions for fear that they will not be able to carry them out effectively or use the funds given to them efficiently. Finally, their limited administrative capacity greatly hinders their ability to levy and collect taxes or mobilize their own sources of revenue".

In Mexico, budgetary resources have been reallocated in several ways. Although total federal government expenditure on health has been reduced, the proportion assigned to the health sector increased from 7.5% in 1982 to 8.6 in 1986. Financial resources on services for the uninsured population rose from 27% in 1983 to 33% in 1985. The financial resources to produce health services by the states has grown by an annual 20% in real terms during the period 1984-1986, while the central administrative units have seen theirs reduced by 19%. The states increased their own contribution for health financing by 280% between 1984 and 1985 and the social security institutes also increased the participation in the financing of public health activities. (Alvarez, 1990)

Analysing financial delegation in the decentralization of health services in Mexico, two constant factors set a common pattern between decentralized and centralized health service organization: the continuation of separate federal and state sources of finance -without the state meddling with the federal funds; and the maintenance of the federal labour relationship with all state health workers- right up to the director or minister of health. Thus, all decentralized state health services, whether

called ministries, departments or institutes became -from the point of view of finance and control- de facto, parastatal organisms of both the state and the federal governments (Frenk-Gonzalez, 1992).

In Brasil, the new mechanism of funding health system, whereby payments are made by a national institution for medical assistance for the services performed by state and county health secretariats, has established a financial dependence that is incompatible with the devolution and autonomy of the different spheres of power. For instance, counties cannot spend this money on one particular local health policy- a health education program, for example-but can only spend the money on hospital treatment and outpatient consultations (Araujo, 1997).

In Colombia, there is numerous laws and regulations on power-sharing with municipalities which are only now coming to fruitition in the context of municipal life. In Colombia's daring vision of decentralization, 41% of incoming revenues will be transferred to the departmental and municipal levels by 2000. But decentralization is bearing fruit in Colombia. Municipal tax revenue rose from 4.7% to 7.6% between 1980 and 1991 (while income from national taxes stayed at 83% and the provincial level dropped). Spending has kept pace with revenue. Municipalities' contribution to the gross domestic Product is increasing (Andrew, 1997).

In Chile, capital investment funds are now requested through the regional financing system, which is under the direct control of the regional governor. Most new proposals for local projects or programmes are now decided upon by the area health services themselves. Decentralization has resulted in quicker management decisions, for example on staffing matters; however, decentralization has had two important adverse effects. It has made national control of the distribution and transfer of health workers much more difficult. In addition, since financial resources are more limited, it has become harder to finance large capital projects and new programmes, without new financial allocations being made by the Ministry of Health. (Montoya, 1990).

In sum, both centralizing financial authority and decentralizing administrative authority tendencies coexist in the health systems of developing countries. In a complicated and often seemingly confused manner, these tendencies combine and conflict with one another, with the centralizing tendency remaining unquestionably dominant. However, this tendency results in the overconcentration of decision making at the top of the hierarchical structure and in turn generates decentralizing efforts aimed at decongesting the overloaded apexes of decision making within central ministries of health. In this environment, the posibilities for the devolution of financial power from central bureaucratic agencies to local health units are not very favorable. In this sense any financial issue for health care decentralization is related to the new financial authority and control at local level on source of finance, funds of financing and new mechanisms for resource allocation and final use of financial resources at local level.

FINANCIAL ANALISIS FOR HEALTH CARE DECENTRALIZATION: THE FRAMEWORK FOR ANALYSIS.

According to the financial aspects for decentralization mentioned above, there are three levels of analysis to study and understand the effects and the relationships between financial aspects and type of decentralization. With the idea of generate a theoretical frame to analyse and evaluate the most important financial aspects for the decentralization procces and the policy intended for a more equitative and efficient resource assignature, it follows levels of conceptual approximations that will serve as a reference for the framework:

The concept and the meaning of financial analysis in health care

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-Concept of financial analysis
-Meaning of Financial analyisis
-Clasification of financial indicators

The concept and the meaning of health care decentralization

-Concept of decentralization
-Meaning of decentralization
-Types of decentralization

Financial analysis and health care decentralization.

-Major variables of analysis
-Relationships
-Financing sources and decentralization
-Financing funds and decentralization.
-Health providers and decentralization
-Mechanisms for resource allocation and decentralization
-Final use of resources and decentralization

The concept and the meaning of financial analysis for health care decentralization.

The concept of financial analysis. The financial aspects for decentralization includes the analysis of several financial indicators to understand the changes in the financing policies for health care

reform in developing countries (Arredondo et al, 1993). The most commonly used conceptual framework of dynamics financial aspects for health includes the definition of health expenditure on activities whose primary purpose is health improvement. This excludes large programs which have health effects, but whose primary goal is not health: for example, general foods subsidies, housing improvement, and large urban water supply projects. However, this definition does leave room for significant differences in how countries account for health-related programs such as targeted nutritional services and water quality improvements (Hernandez et al 1995. Ramesh, 1997).

Recently there is a new, and more appropriated method to analyze the financial dynamic in health care with recent aplications for developing countries, this method has been called: National Health Accounts. The core concept of national health accounts is defining the **flow of funds**. Experience in applying of this concept in developing countries suggests that approaches used in countries like US should be adapted to the specific needs of developing countries, as well as the more limited data available, and according with the research questions. This requires modifying definitions of both sources and uses (Berman, 1996).

One approach, used in Egypt, Mexico, and Colombia, is formulate the flow of funds in terms of three major levels: the original ***sources of finance***, the ***financing funds,*** and the health care ***providers*** (Frenk et al, 1996). Taking into account the objectives and the research questions for this study, in order to analyze the financial aspects for health care decentralization, we agregate two levels more: the **final destiny** or financial resources utilization for different health programs and the **mechanisms for financial resources allocation**.

The meaning of financial analysis for health care decentralization. Independently from the patterns of decentralization, as was menthioned at the begining of this section, there are five indicators that must be defined to analize and understand the financial aspects for health care decentralization: **The financing sources**, **the financing funds**, **the health service provider institutions**, **the final destiny of the resources**, and the **mechanisms for financing allocation.**

-The financing sources. Could be defined as the primary economic sources that provide the resources to the population for different activities. Depending on the origin of the economic amounts, there are four sources of financing, classify as internal and external. In the case of the health system, the internal sources consist in the government, the industry and the households, and the external ones are refered to the exchange that takes place within the health sector, through multilateral or bilateral agencies (Mills, 1991).

-The financing funds. The financing funds are the recervoirs of the economic sources, their rol is to administrate the resources and to buy the medical services, these could be real or virtual funds. This is important since the virtual funds could only be used in an individual maner and they are in constant competition with the acquisition of other satisfiers. They depend on the individual preferences and they could be drastically reduced at times when the income drops, as a result of economic crisis and the adjusment policies.

-The health service provider institutions. The health service provider institutions are the government and non-government organizations providing health care services for the population. According to the source of finance and the consumers, the provider institutions are classified in three: social security, public assistance and the private sector (Lee, 1983. Frenk,1996).

-Mechanisms for financing allocation. The mechanisms for financial resources for health expenditure include legal, political and technical principles that permit a way for financial resources allocation for the production of health care services, and for the financing adjustments for health care decentralization.

-The final destiny of the resources. It refers to the classification of the health expenditure by the health service providers, according to their final destiny and depending upon the financing fund. For this reason, the following criteria will be used for the classification: for supporting programs, for current expense factors and investment and for the care units.

The concept and the meaning of health care decentralization.

The concept of decentralization. Decentralization for health care is defined here as the transfer or delegation of legal, political, technical and financial authority to plan, make decisions and manage public functions for health systems from the central guvernment and its agencies to field organiztions of those agencies, subordinate units of government, semiautonomous public corporations, areawide or regional level development authorities; functional authorities, autonomous local governments or nongovernmental organizations (Rondinelli,1981).

The meaning of decentralization: Health and health-related services, while they can be looked at as a system in their own right, are also part of a wider government and social system that place limitations on their behaivour. It is therefore important to describe and analize the main forms of decentralization and to see what they imply for the organization of health system in developing countries.

Decentralization can be broad or constrained in scope. The degree of responsability for and discretion in decisionmaking that is transferred by the central government can vary, from simply adjusting workloads within central government organizations, to the divesting of all government responsabilities for performing a set of what were previously considered to be public sector functions. This evident complexity makes it necessary to distinguish among the major types of decentralization that have been tried in developing countries (Bossert, 1996). According with Rondinelli approach (1981), they can be categorized into the next four types:

-Deconcentration. The term "deconcentration" Is applied to the handing over of some administrative authority to locally-based offices of central government ministries. In the case of health, an example would be a district-level office of a ministry of health. Since deconcentration

involves the transfer of administrative rather than political authority, it is seen as the least extensive form of decentralization.

-Devolution. This type of decentralization is the creation or strengthening of subnational levels of government (often termed local government or local authorities) that are substantially independient of the national level with respect to a defined set of functions. They normally have a clear legal status, recognized geographical boundaries, a number of functions to perform, and statutory authority to raise revenue and make expenditures. They are rarely completely autonomous, but are bodies largely independient of the national governmen in their areas of responsability rather than subordinate administrative units as in the case of deconcentration.

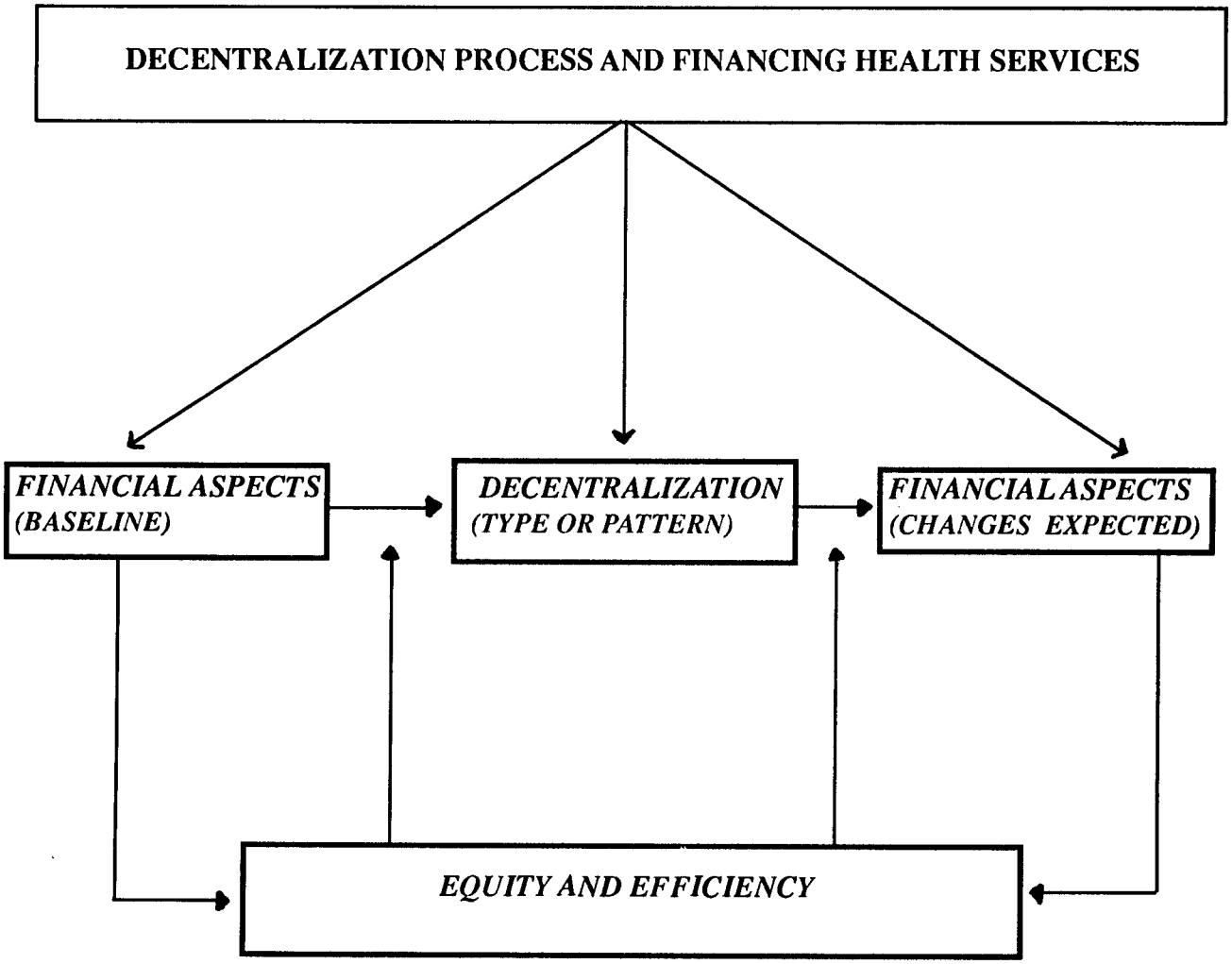
-Delegation. It involves the transfer of managerial responsability for defined functions to organizations (often termed "parastatal organizations") that are outside the central government structure and only indirectly controlled by central government. Governments may see delegation as a way of avoiding the inefficiency of direct government management, of increasing cost control, and of setting up an organization that is responsive and flexible. In the health field, delegation has been used to manage teaching hospitals and to organize the provision of medical care financed by social insurance, specially in some Latin American countries.

-Privatization. It creates a contractual relationship between public entities and private providers of services. Privatization involves the transfer of government functions to voluntary organizations or to private profit-making or non-profit-making enterprises, with a variable degree of government regulation. Many developing country govrnments have long depended on voluntarry organizations for the provision of health services. Some have seen this as a temporary phenomenon, the services to be absorbed by the government once resources permit.

Some governments have used all four types, simultaneously or at different times. Some began with one approach and later shifted to another after assesing initial results. Other governments have used various combinations of the four. A number of countries have devolved development management responsabilities to local guvernments but have maintained strong indirect controls over them (Abel-Smith, 1988) . Privatization has usually evolved from situations in which private sector firms began offering goods and services that government provided poorly, or not at all, or only in some parts of the country, rather than from deliberate efforts by governments to divest themselves of public functions (Berman, 1996).

Decentralization of government authority can thus take a variety of forms. Moreover, countries may make use different types at the same time for different functions. For example, certain government functions may be devolved to local government, while others are deconcentrated to local administrations of government ministres (Dahlgren, 1990) . The distinction between the four types of decentralization is based essentially on their legal status. In reality, however, other factors (e.g., financial authority, means of representation of the local community) are also important in a particular country may have features from more than one type. Thus, the four type of decentralization presented should not be seen as necessarily clearly distinct from each other.

FIGURE 1: THEORETICAL MODEL (I). RELATIONSHIPS BETWEEN FINANCIAL ASPECTS AND HEALTH CARE DECENTRALIZATION.



The characteristics of deconcentration and devolution, for instance, may overlap, and a reform in a particular country may have features of both. In particular, forms of local government with a high degree of autonomy tend to be rare in developing countries; instead, health local institutions have been created that provide some local discretion while retaining substantial central influence from the ministry of health, particularly over policies and resources (Cassels, 1995) .

The relationships between financial analysis and health care decentralization.

Taking into account the four types of decentralization and the five financial indicators to analize the financing changes to can develop and implement an effective processes of decentralization for the governmental health sector, the figures 1 and 2 includes the relationships between financing and decentralization in the context of health care reform for developing countries.

Figure 1, includes three main variables that may identify, in general terms, the elements of analysis on financial adjustments for the equity and efficiency of the decentralization process in the context of health care reform. The antecedent variable is represented by financial aspects before decentralization , the predictor variable is represented for the type or pattern of decentralization implemented, and the dependent variable is represented for financial changes after decentralization. There is a modifying variable represented for the equity and efficiency before and after decentralization affecting before the type of pattern of decentralization designed and implemented and after the adjustments on financial aspects.

Figure 2 illustrates in a more detailed way all elements of analysis and the hypothesis derived from the theoretical model presented in figure 1. The scheme identifies the basic indicators of the flow and allocation for financial resources before decentralization: source of finance, funds of financing, providers, mechanisms for resource allocation and final use of resources. The scheme also identifies the main effects of decentralization on the financial aspects, according to the changes expected after decentralization: more control financing and authority at local level, more revenues at local level, decrease or increase in local funds according to local preferences, budget control for providers according to priority groups at local level, new technical, political, social and legal principles to design and implement new mechanisms for resources allocation and setting priorities for final use of resources in relation to helath system and health conditions population variables.

The process and the impact of the expected financial changes depends on the type of pattern of decentralization that is implemented in order to get more equity and efficiency in the use and allocation for financial resources during decentralization. In this figure it is important to stress that financial indicators, changes expected in health financing, and results on efficiency an equity, have an indirect relationship with the type or pattern of decentralization that each country implements. In this way there is a circular relationship that provides feedback and assesses constantly the objects of study in this research proposal: financial indicators, decentralization procces, and efficiency and equity principles. According to the theoretical model exposed, following is a brief statement of the main hypotheses that this research proposal intends to test.

FIGURE 2: THEORETICAL MODEL (II). RELATIONSHIPS BETWEEN FINANCIAL ASPECTS AND HEALTH CARE DECENTRALIZATION.

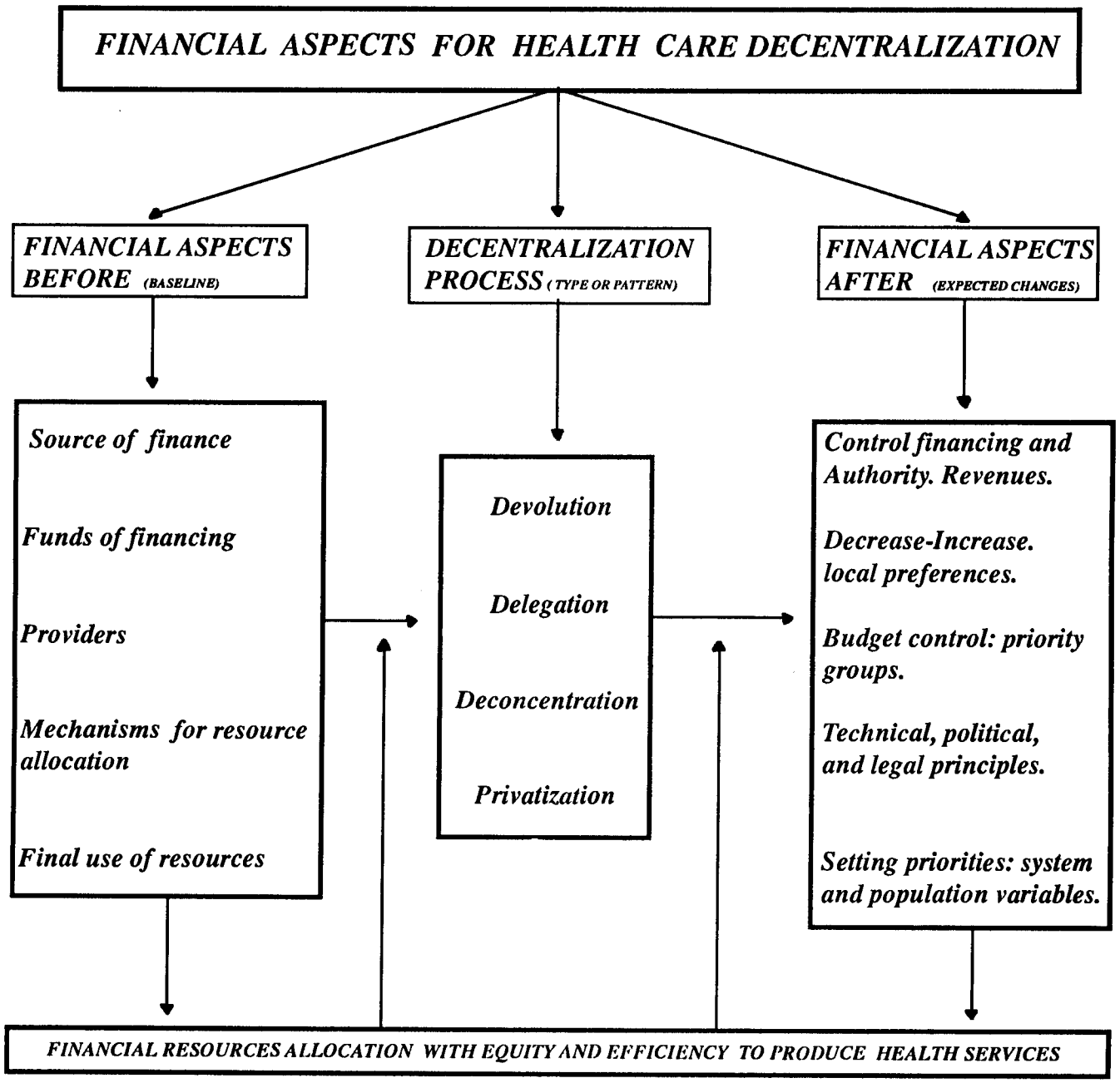


Figure 2 illustrates in a more dethailed way all elements of analysis and the hypotesis derived from the theoreticall model presented above. Following is a brief statement of the main relationships between financial aspects and health care decentralization that the framework intends focus.

Source of finance-and decentralization. Many changes in responsability for sources of finance occur as a result of decentralization, indepently the type and the pattern. The local government is required to assume some responsability for health care financing. Therefore local level must assume more control financing and authority on the absolute amounts of financial resources. It also include more and new strategies to raise revenues locally and to negociate with national and international levels the control on source of finance (Abel-Smith, 1967. Mills, 1990).

Funds of financing and decentralization. The effect of the financial changes in the recervoirs in the initial stages of decentralization is that economic sources could be reduced. In the decentralization process they depend more on invidual preferences and they could be drastically reduced at times when the income drops at local level, and as result of economic adjustments for the new budget to every fund of financing (WHO,1993. WB,1993. Hsiao,1994).

Providers and decentralization. The changes affect the nature and range of resource allocation and budget control at different levels by each institution (public asistance, social sevcurity and private sector). In order to have more budget control each provider instituition must design a new monitoring and assessment programme for final use of resources and new mechanisms for resources allocation (Abel-Smith, 1988. Frenk, 1996).

Resources allocation and decentralization. The effect of decentralization process on resources allocation is very much related with epidemiological changes at local level and with the new technical, political, legal and institutional principles to implement new mechanisms for resources allocation and to analize the financial resources required for next years at local level. It must include mechanisms designed with the combination of three variables: type of medical care (prevention, promotion, curative, rehabilitation), type of disease (infectous disease, chronic disease, accidents and violences), and type of institution (public assistance, social security, private sector) (Bobadilla, 1990. Arredondo, 1997).

Final use of resources-and decentralization. With decentralization process health policy makers at local level must design and improve new and differents equity ways for the final use the resources depending of local health priorities and according with two major variables: system variables (the supporting programs, the current expense factors and investment, and the health services to produce), and population variables (include the type of services demanded at local level: priamary care, secundary care and third care) (Musgrove, 1990. Jamison,1991).

DISCUSSION AND CONCLUSSIONS

The framework proposed could be used as a research analytical framework and to analyise the formulation, implementation and assessment the financial aspects before and after health care decentralization. It should also cover a conceptual reflection on financial changes and decentralization. This is not to suggest theoretical reflection away from the concerns of reality. Rather, the proposal is for greater recognition of a theoretically informed understanding of the main financial changes for decentralization as a basis for developing effective processes of decentralization appropriate to health policy objectives particularly for the health financing indicators and the clarification of the different points of compatibility and incompatibility at national, regional and local level between the source of finance, funds of financing, providers, new mechanisms for resources allocation, and final use of financial resources.

Recognizing the difficulty of establishing direct causal links between different forms of decentralization and changes in the financial aspects, the framework for analisys facilitates the search for plausible links between its different components and other important events. Equally, acknoweledging the difficulty of arriving at universal conclusions, the framework underscores the need for examining the specific conditions under which certain changes in health financing and certain forms of decentralization achieve the desired effect before drawing overly optimistic conclusions about the transferability of lessons from one country to the next.

The diferents componnents may be used to analyse the financial changes in health sector in developing countries at different stages of decentralization. Where decentralization has been in place for some time, it is reasonable to expect certain changes in the way the new changes for health financing functions. For countries with mature decentralization, all five financial indicators of the framework will therefore be used.

For countries that have only just formulated their policies, and determined the means for implementation, or where implementation has begun only recently, it is arguably not appropiate to look for change beyond organizational structures and processes. In these situations, the analysis will refer to only the way in which the components of the framework can contribute for the design instruments and methodology for the assessment and analysis a posteriori. In other words, the all components may be used to consider financial variables to be monitored for prospective analysis of the effects of decentralization on financial aspects.

There is a growing interest in developing an understanding of the process by which health sector reform is formulated and implemented. This interest follows on from concern over the difficulties encountered in the implementation of health sector decentralization. At the same time, such an interest emphasises the context in which financial changes takes place and warns us against the search for standard frameorks for health sector reform in developing countries.

We know so litle about how to demostrate effectiveness of institutional patterns, political and financial processes because so litle has been invested in developing indicators, criteria and consensus

on what constitutes success in these fields. The framework proposed was designed for rapid rather than exhaustive analysis and assessment, particularly when studing the effects of decentralization on equity, efficiency and effectivenes, using financial indicators. It is to help primarly with retrospective analysis, and for this purpose must rely on information likely to be available now. Key components have been chosen with this criteria in mind.

In this sense, the framework stress the changes in the five main financial indicators to understand the macroeconomic dynamic for health systems in the context of decentralization, including the expected changes for the following relationships: the source of finance and decentralization, funds of financing and decentralization, providers and decentralization, new mechanisms for resources allocation and decentralization, and final use of financial resources and decentralization.

Cualquier cambio que se genere en las fuentes de financiamiento a partir de la implementacion de la decentralizacion tendra un impacto importante tanto en los proveedores como en los consumidores. Cambios en las fuentes de financiamiento deberan estar estrechamente relacionados con la autoridad financiera a nivel local para el control, presupuestacion, asignacion y monitoreo de la utilizacion de los recursos financieros. Por otra parte en el corto plazo las autoridades de ambos niveles, federal y regional, deberan trabajar fuertemente en el diseno e implementacion de los mecanismos de ingresos al sector salud a nivel local via impuestos, via venta de servicios personales y no personales de salud.

Nuevos lineamientos para los fondos de financiamiento en el contexto de la decentralizacion estan relacionados con los fondos para poblacion asegurada, fondos para poblacion no asegurada que utiliza los servicios de salud de la asistencia publica (ONGs y Ministerios de Salud) y fondos para poblacion no asegurada que utiliza servicios privados de atencion medica. Los tres componentes deberan tomarse en cuenta para el analisis de las variables que favorezcan la efectividad de la decentralizacion, sobre todo si se inclye la variante de privatizacion como un tipo de decentralizacion. Independientemente del patron de decentralizacion habra un efecto regresivo sobre los fondos y las fuentes de financiamiento en salud, de manera que los recursos a nivel local estaran siendo utilizados por los proveedores y consumidores a nivel local, sin entrar en la competencia por la asignacion de recursos a nivel nacional o regional.

Los cambios financieros esperados con la decentralizacion presentaran ventajas y desventajas importantes a nivel estatal dependiendo de la relacion que guarde el ingreso per-capita estatal con el ingerso per-capita nacional, por lo que pueden presentarse incrementos o decrementos en los montos financieros de los fondos para los diferentes grupos prioritarios a nivel estatal. En este sentido para los estados donde el IPC sea mayor a la media nacional el efecto regresivo sera altamente favorable; para los estados donde el IPC sea similar a la media nacional el efecto regresivo sera favorable; finalmente para los estados con IPC menor a la media, el efecto regresivo sera desfavorable. En este caso los cambios financieros deben hacerse con mayor cutela dado que no se puede descapitalizar al sector salud. Por esta razon, entre otras, los cambios financieros en el sector salud deberan ser en funcion de una combinacion de mecanismos o tipos de decentralizacion, de manera que exista factibilidad tecnica, politica y financiera entre el tipo de decentralizacion y la capacidad financiera de los diferentes estados. En otras palabras no se puede regresar toda la autoridad financiera a estados

que no cuentan con los recursos necesarios para el mantenimiento de los programas de salud vigentes.

Es un hecho que en los paises en desarrollo los proveedores de la atencion medica trabajan con diferente cultura organizacional, al igual que en los paises desarrollados, dependiendo de los grupos prioritarios a atender. Los cambios sobre las politicas de financiamiento deberan considerar el marco legal, politico, tecnico y normativo en el que se basa tal cultura organizacional de cada institucion. Lo anterior garantizara mayor efectividad en la manera en que cada proveedor podra hacer uso de sus propios recursos financieros a nivel local, teniendo un control del presupuesto asignado a la salud, pero sobre todo orientandolo hacia la estratificacion de grupos prioritarios a nivel local.

Antes de la decentralizacion, los estados recibian desde el nivel central y a partir de un perfil epidemiologico con una media de morbilidad y mortalidad nacional, los lineamientos para la produccion de servicios considerados en programas verticales de salud sin importar si el perfil epidemiologico a nivel estatal estaba por abajo, igual o por arriba de la media nacional. Con la decentralizacion, los mecanismos de asignacion y utilizacion de recursos financieros deberan replantearse en funcion de principios tecnicos, politicos y legales a nivel local. Sobre todo deberan replantearse en funcion de las demandas que se esperan para el corto, mediano y largo plazo a partir de los cambios epidemiologicos entre enfermedades cronicas, infecciosas, accidentes y violencias.

En lo relativo al uso final de los recursos, los cambios esperados a partir de la decentralizacion estan ampliamente relacionados con la eficiencia con la que se asignen y utilicen los recursos financieros de acuerdo a las demandas locales de salud. En efecto, la decentralizacion conlleva hacia la necesidad de establecer las prioridades de atencion medica a partir de la infraestructura de los sistemas de salud pero tambien de los determinantes de la salud sobre todo al nivel local. La equidad puede plantearse a partir de los cambios financieros en la implementacion de la decentralizacion a partir del analisis de los mecanismos de asignacion de recursos para la salud.

Es necesario resaltar que el analisis de los cambios financieros a partir de la decentralizacion, sobre todo de los cambios en los cinco indicadores economicos incluidos en el marco propuesto, sin duda alguna puede utilizarse como una herramienta de estudio cognoscitivo y metodologico, desde una perspectiva economica, para el analisis de los principios de equidad en la asignacion de recursos para la salud; de eficiencia en el uso racional de dichos recursos y de efectividad en la implementacion exitosa de la decentralizacion en relacion con variables contextuales de los sistemas de salud y de las necesidades de salud.

En efecto, la utilizacion del marco propuesto, permitira conocer la efectividad con que se relicen cambios financieros equitativos y eficientes para lograr un proceso de decentralizacion acorde con las reformas en salud dependiendo finalmente de los siguientes aspectos: El nivel apropiado de gobierno para la decentralizacion, el cambio de roles entre ambos niveles, la factibilidad contextual de ingresos y egresos sobre los cambios en el financiamiento, la coherencia entre el patron de decentralizacion-cambios financieros y condiciones locales del sistema de salud y de las necesidades de salud, la redistribucion de la autoridad en todos los niveles, la participacion de la comunidad, la compatibilidad entre el tipo de decentralizacion y los principios de equidad, eficiencia y efectividad.

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Appendix 4

Comments, sugestions and proposal for reestructuring the manuscrit: Macroeconomic Adjustment Policies, Health Sector Reform and the Impact on Acces, Utilization and Quality of Health Care

COMMENTS AND SUGGESTIONS TO THE MANUSCRIT: MACROECONOMIC ADJUSTMENT POLICIES, HEALTH SECTOR REFORM AND THE IMPACT ON ACCESS TO, UTILIZATION AND QUALITY OF HEALTH CARE. Enis Baris and Luis Duran.

Armando Arredondo. Ottawa. August, 1997.

These comments are given section by section following the order in which these sections appear on the draft document. Based on these comments a proposal is advanced on how to restructure the draft in order to develop a new version.

INTRODUCTION.

- The draft document makes reference to the austerity measures imposed mainly by the World Bank and the International Monetary Fund but those policies are not clearly and precisely defined. I believe a definition of macroeconomic adjustment policies (MAPs) and of health reforms is required. How can the process be conceptualized, how is it perceived and implemented in different countries, and how is it linked to adjustment policies.

- The article objectives are not clear. It mentions that it offers a conceptual model to evaluate adjustment policies in general and health reforms in particular. This would give the impression that the whole article deals with a conceptual model which, as mentioned on the previous paragraph, is beyond the scope of the article sections.

- The last paragraph of the introduction (page 3) begins by stating that the article offers a conceptual model but it proceeds to state that the article is organized in four sections without further mention of this conceptual model. A theoretical model is included among the four sections listed. This theoretical model appears to have been confused with the conceptual model. The conceptual model should be included, at least as a section of the article, and the differences between it and the theoretical model should be indicated.

GENERAL DESPCRIPTION OF THE TOPIC.

- Some of the contents are confusing. A research proposal and an article appear to have been mixed together. For example, on page 2, paragraph 2, the draft document states that: *"From this we present an analytical model intended to guide our investigation of this complex subject"*. On page 2, paragraph 3, it states that: *"we wish to examine the role of MAPs in bringing about health sector reform. We are interested in assessing the impact of MAPs from*

two different perspectives. The results will increase our understanding of the relationship between various sectors of economy and the health sector reform....". These statements create confusion. Are these the goals and benefits expected from a research project or the objectives of an article?.

TOWARDS A THEORETICAL FRAMEWORK.

- Some paragraphs include categorical statements that require identifying the reference from which such an idea was extracted. Otherwise they are just questionable value judgements without empirical justification. For example, on page 4, paragraph 2 it states that: *" Since the early 1980s, most developing.....".*

- The first two points of this section, economic crisis and the influence of international agencies, appear to be too succinctly stated, being mentioned only in very general terms. As a matter of fact, the influence of international agencies is not discussed. This is an important point to clarify in my opinion. It would also be useful to analyse this influence at the specific level of the effects it has had on the health sector, and to review the effects of the crisis to be able to identify the situation that prevailed in the health system before the implementation of the MAPs.

- The first paragraph regarding the health systems crisis states that, according to Frenk *et al.*, serious accessibility, quality and equity problems have been generated. What that reference actually says is that the accessibility, quality and equity problems have become more acute but not that they have been generated, as the document states. This section should define the present health systems situation. Its determinants should be identified to allow subsequent correlation with the MAPs.

- Some of the contents are too general. The need for developing them in more detail or eliminating them from the text should be evaluated. Political, socio-cultural, and institutional issues are good examples of this problem.

- In practice, the paragraphs dealing with macroeconomic adjustments and health reforms only discuss reforms in general but not specifically health reforms. These paragraphs mention health reforms only as an integral part of the macroeconomic adjustment policies or as a type of structural adjustments. These comments further highlight the need to define, conceptually and operationally, the central ideas of this article.

- Adjustment policies and health reforms are said to vary both in degree and intensity, depending of the country to which they apply. However, when stating that the policy stabilization period does not by itself guarantee achieving the MAPs objectives, reference

is made only to Mexico when reviewing the results. It would probably be useful to include more empirical results from other countries to technically justify the statements made.

-It is difficult to understand the logic determining the order in which the issues are presented. For example, the document deals first with macroeconomic adjustment policies and health sector reforms. Later on it deals with adjustment policies giving concrete examples. It would appear that very general and very specific analysis levels have been mixed. If this is the case, the contents should be reviewed to achieve a coherent logic, better suited to the article objectives.

-In the section regarding health system performance and health sector reforms emphasis is made on an analysis model proposed by Hsiao. The last paragraph states that, in this proposal, (research proposal or article proposal?), a similar analysis framework is applied to evaluate the impact of MAPs and health sector reforms over health results. It is not clear which is the analysis framework being used nor what are the similarities. It should also be emphasized that the statement *" in this proposal we use...."* mixes once again the idea of an article with a research proposal. This is repeated in the last section of the document, where methodological considerations for the proposal are listed. Those considerations bear no relation to the article.

- The discussion regarding macro-adjustment policies and their impact on the community starts by stating that there is substantial analysis on this issue in most developing countries and makes reference to reductions in social expenditures, with specific reference to reductions in health expenditures.

- This should be reviewed and documented in more detail since, at least in countries such as Mexico, Chile, Peru, Argentina, Brasil and even Nicaragua, health expenditures in constant currency have actually shown an upward trend since the mid 1980's. The problem with health expenditures is, among others, management inefficiencies and lack of technical criteria to define the financial resources allocation mechanisms, but not the amounts assigned by the different funding sources.

- Regarding the section dealing with adjustment policies, health reform and results: I believe that the FUNSALUD reference cited, in the paragraph that indicates that negative effects have been observed in Mexico during the last decade regarding death rates, disease rates and care quality, does not correspond to the statements made. The last paragraph of this section proposes a theoretical model. This model is supposed to be detailed in the following section but a conceptual model is given instead. As previously mentioned, the same confusion between a theoretical and a conceptual model takes place in the introduction.

- It may be appropriate to update the content with more recent literature references, such as

recent reports from the World Bank, the UN Report on Development, etc..

CONCEPTUAL MODEL.

- In this section some definitions regrading basic concepts, such as access, usage and quality, adjustment policies, health reform, health system, etc, are to be expected. Nevertheless, only cause and effect potential relations are examined to justify some working hypothesis more appropriate to a research project than to an article.

- The article should deal with this section in a more substantive manner as the introduction identifies this subject as the main contribution of the document. Is this really a conceptual model or is it making the variables operational to approach the subject under study? Is this a theoretical or a conceptual framework?

POTENTIAL RESEARCH HYPOTESES.

- The different contents of this section could be reexamined in the discussion but not in the manner done in the draft.

METHODOLOGICAL CONSIDERATIONS.

- This section is not related to the subject under study. This is a proposal for an article, not for a research project. The subject of the article is about the framework (teorethical or conceptual) is not about the results from a research project.

BIBLIOGRAPHY.

- A detailed literature review could be undertaken after the document has been restructured. For example, two references are made to Frenk (1994 and 1995), but the text only cites one. FUNSALUD is cited the text but does not appear in the list of references.

PROPOSAL FOR RESTRUCTURE THE DOCUMENT:

Based on the above mentioned comments, and having in mind the potential publication of the document, I propose it could be restructured both in content and in format. If this proposal is accepted I would be willing to develop any of the different issues. If this proposal is not accepted we could discuss it and revise it. The format and the contents could

be restructured as follows:

a) Introduction:

- Define the problem being studied.

- Define the study approach.

- Define the article objectives.

b) Framework proposed:

- Define adjustment policies, macroeconomic adjustment policies, reform, health reform, and particularly what is meant by usage, access and quality.

- Conceptual and operational justifications would be required in this section, as the problem is approached through these three result indicators rather than through others, such as productivity, equity, financing, technology, accessibility, etc.

- Define the principal components of the analysis framework and explicitly indicate if it is a conceptual, an analytical or a theoretical model without mixing these frameworks. This would result in a clear proposal rather than in a confusing one.

- Develop a chart indicating the main components of the framework and their interrelations at the level of the three study variables: macro adjustment policies, health reforms and health results.

- Explain that it is a framework for the analysis of causes and effects between adjustment policies, health reforms and health results.

- These hypothesis can be the basis for developing in detail each of the cause and effect relationships that the proposed framework would contribute to the study of the problem.

c) Discussion and conclusion:

- About the main components of the proposed framework.

- About the framework benefits for the study of adjustment policies, health reforms and health results.

- About the limiting factors that should be taken into account to effectively apply this analysis framework in differents developing countries.

Appendix 5

Comments and sugestions for research proposal reviewed

COMENTARIOS AL PROYECTO POLITICAS DE AJUSTE MACROECONOMICO EN NICARAGUA.

Ottawa, Canada. June 19,1997.

Los comentarios se han dividido en dos secciones : comentarios de caracter tecnico y comentarios sobre la forma de la propuesta. Dichos comentarios estan planteados de acuerdo a la estructura de la propuesta. Antes de pasar directamente a los comentarios, es importante resaltar que la idea de estos es con el objeto de hacer los ajustes pertinentes para garantizar con el mayor rigor cientifico el alcance de los objetivos del estudio, previniendo o tratando de controlar cualquier elemento de la realidad que se pueda presentar al momento de operacionalizar la propuesta.

1) Comentarios sobre los contenidos tecnicos de la propuesta:

-PLANTEAMIENTO DEL PROBLEMA Y OBJETIVOS:

a) Partiendo de la idea de que la precision y claridad del planteamiento del problema son un elemento determinante para las siguientes secciones de toda propuesta de investigacion, se recomienda plantear las preguntas de investigacion, que estan implicitas en esta seccion, de manera explicita.

b) En cuanto a los objetivos de la propuesta existe un grado de confusion que pudiera aclararse planteando un objetivo general del cual se deriven los objetivos especificos. Si se acepta este comentario, con la idea de dar mayor precision y claridad a la propuesta, podrian ajustarse los objetivos que estan planteados en el documento, dirigiendolos mas hacia el analisis en el sistema de salud de Nicaragua y explicitando cual es el objetivo general de donde se derivan los otros cuatro objetivos, que al parecer serian los objetivos especificos.

c) El ultimo de los objetivos que se menciona en la pagina 7, plantea la utilizacion, acceso y calidad de la atencion como trazadores de equidad y despues se menciona que estos indicadores evaluaran el impacto de las PAM; entonces el objetivo genera cierta confusion o ademas se evaluara la equidad o atraves de la equidad se evaluara el impacto de las PAM ? . La equidad dificilmente se puede analizar a partir de la accesibilidad, calidad de la atencion o utilizacion de servicios. Cualquiera que sea el caso se recomienda revisar a detalle este objetivo y tomar en cuenta el marco teorico para hacer los ajustes pertinentes.

MARCO DE REFERENCIA:

d) Seria recomendable revisar a detalle que es lo que se quiere decir cuando en el marco de referencia se habla de la equidad y eficiencia como parte de los valores donde se evaluaran las PAM y ademas se plantean diferentes criterios para evaluar la equidad (universalidad, globalidad, accesibilidad y satisfaccion de la poblacion). Pagina 22. Cual es la idea de introducir la discusion

de estos conceptos ? Ayudan a dar claridad y precision a la propuesta.? Es para ampliar las variables de estudio ? .

e) Podria ser relevante, para la propuesta, considerar una seccion en el marco de referencia o planteamiento del problema donde se esquematice como esta constituido el sistema de salud de nicaragua y como ha presentado cambios estructurales en los ultimos 15 anos. En este caso se podrian incorporar los cambios, en la seguridad social y en el MINSA, que ha tenido el sistema de salud de Nicaragua para la evaluacion de las PAM.

MODELO TEORICO E HIPOTESIS:

f) En el modelo teorico podria considerarse la definicion de los conceptos centrales del estudio. Resulta interesante como se mencionan los conceptos de acceso, utilizacion y calidad de la atencion, pero sin ser definirlos el analisis y discusion de dichos conceptos queda un tanto limitado. Se plantean las relaciones entre las variables pero no se definen las variables y el tipo de relacion. Respecto a definiciones conceptuales-teoricas, tambien valdria la pena considerar una definicion precisa de las PAM y de lo que se entiende por reforma del sistema de salud, estas consideraciones serian de suma importancia para poder operacionalizar la definicion conceptual en una definicion nominal de las principales variables de estudio. Lo anterior seguramente ayudara al planteamiento metodologico de la propuesta.

g) Existen posibles errores de traduccion en la figura-modelo de las variables. Por ejemplo "perceived quality of care" esta traducido como "calidad atencion percibida", la traduccion correcta es "percepcion de la calidad de la atencion". En este punto, por ejemplo, no se especifica si el modelo se refiere a la percepcion por parte del proveedor o el consumidor, aunque pareciera que del consumidor. Igualmente "User's perceived quality" se traduce " calidad atencion percibida", cuando la traduccion correcta es "percepcion del usuario sobre la calidad". Estos errores aunque son de traduccion podrian tener consecuencias tecnicas sobre el marco teorico y las variables de medicion por lo que se considera importante revisar y ajustar donde sea necesario la traduccion.

METODOLOGIA:

h) En cuanto aspectos metodologicos, ademas de tomar en cuenta los lineamientos de la propuesta lider de IDRC, seria recomendable que en cada seccion metodologica se pueda encontrar respuesta a los detalles de procedimientos metodologicos de acuerdo a la disponibilidad de informacion e infraestructura para el caso de Nicaragua. Por ejemplo, se propone, aunque no queda muy claro, varios ciclos de medicion o solo se mencionan (pagina 30-31). Si se quiere llegar al detalle metodologico, habria que determinar los ciclos de medicion de acuerdo a los criterios que se proponen. Se mencionan actividades a realizar en terminos globales pero seria necesario incluir los procedimientos detallados para cada actividad. Para dar algunas ideas de como se podria ajustar la seccion metodologica, a continuacion se plantean algunos cuestionamientos que pueden servir de guia para tal efecto:

-De que bases de datos secundarios se obtendra la informacion ?

-Cuales seran los procedimientos metodologicos para la calidad, validez y confiabilidad de la informacion secundaria ?

-Cuales los metodos y tecnicas para la recopilacion, validez y analisis de datos primarios ?

-Cual es el plan de analisis que se seguira entre variables macro y micro ?

-Cual sera el metodo de muestreo y como se calculara el tamano de la muestra por municipio ? Se cuenta con un marco muestral para identificar hogares o hay que disenarlo ?

- Segun se entiende la seguridad social desaparecio como tal en el gobierno sandinista y reaparece en el gobierno de Chamorro, Como se estratificara la poblacion para separar a los asegurados antes del 90 y despues del 90 ?

-Como se manejaran las empresas previsionales de salud del MINSA y del sector privado ?

-Como se controlara la poblacion por tipo de proveedor antes y despues de los cambios al sistema de salud ?

-Como se diferenciara el acceso, la utilizacion y la calidad de los diferentes consumidores y diferentes proveedores ?

-Como se controlara que los cambios que se presenten esten relacionados con las PAM y no con variables como la estabilidad social relativa de la sociedad nicaraguense por el fin de la guerra ?

-Como se controlara la validez de la informacion, sobre todo la de caracter retrospectivo. Que percepcion de la calidad de la atencion puede tener una poblacion en medio de una guerra civil y como cambia esta despues de la guerra ?. Lo mismo para las variables de acceso y utilizacion.

-Como se obtendra la informacion para periodos anteriores, particularmente para financiamiento ?

-Cuales son las variables cualitativas que se mencionan y cuales las cuantitativas ?

-Cual es el plan de analisis cualitativo ?

-Cual es el plan de analisis cuantitativo ?

-Cual es el plan de analisis comparativo de ambas variables en los diferentes periodos ?

-Que modificacion se hara a los indicies y escalas que recomienda el proyecto de IDRC?

-Cual es la organizacion, coordinacion y supervision del trabajo de campo para datos primarios y secundarios ?

-Cuales seran los procedimientos metodologicos para cada fase del estudio ?

i) Haciendo ajustes que traten de responder a estos cuestionamientos, se facilitara la valoracion sobre la factibilidad tecnica, politica y financiera para concretar cada actividad de la propuesta. Desde otra perspectiva, los ajustes metodologicos que se realicen redundaran en el hecho contar con una propuesta solida y coherente con los objetivos del estudio Macro.

PLAN DE TRABAJO:

j) El cronograma de actividades podria evaluarse con mayor precision si se conocen los pasos metodologicos a detalle. En todo caso se recomienda ajustarlo de acuerdo al detalle de procedimientos metodologicos para cada fase del proyecto, desde la seleccion de fuentes de informacion, hasta el rediseno de instrumentos para datos primarios, sel;eccion de encuestadores, capacitacion de entrevistadores y supervisores, trabajo de campo, diseno de banco de datos, codificacion y analisis de la informacion, interpretacion de resu;tados, etc.

PRESUPUESTO:

k) En cuanto al presupuesto presentado, resulta en terminos muy generales por lo que seria bueno detallarlo, identificando los requerimientos minimos de recursos humanos de tiempo completo, medio tiempo y tiempo parcial; asi como los recursos materiales, epuipo y material de oficina para el trabajo de campo y para cada fase del proyecto.

2)Comentarios sobre la forma:

COMENTARIOS GENERALES:

a) El documento, en varios de sus contenidos es una traduccion de la propuesta original de IDRC. En este sentido habria que hacer una adecuacion a la propuesta, tomando en cuenta los comentarios tecnicos descritos y algunos otros aspectos que el equipo de investigacion considere pertinentes.

b) En algunos contenidos se presenta repeticion de parrafos integros. Por ejemplo ver parrafo ultimo de pag. 15 con parrafo 5 de la pagina 4. Parrafo 2 de la pagina 6 con parrafo 2 de la pagina 4. Valdria la pena revisar a detalle estas observaciones y hacer los ajustes que se requieran.

COMENTARIOS ESPECIFICOS:

c) En la pagina 30, parrafo 3 se menciona una figura que nunca aparece en el documento. Esta dicha figura en la propuesta, se quedo traspapelada o es un error de transcripcion ?

d) Para tener mayor claridad de la actualizacion y pertinencia tanto del marco teorico, revision de la literatura y analisis de estadisticas, se recomienda incluir una seccion de referencias bibliograficas.

e) Uno de los problemas actuales de la investigacion en sistemas de salud es la dificultad de utilizar sus resultados en la toma de decisiones. Plantear una seccion sobre los beneficios que se espera del estudio podria ayudar a tener una guia estrategica para poder programar una promocion y utilizacion de resultados con mayor exito.

f) Para ubicar mejor cada seccion de la propuesta y facilitar su lectura se recomienda numerar el indice de acuerdo a los contenidos que corresponda cada pagina.